MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01613 — 01610

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie-rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie-rural
d. STREET ADDRESS: 604 Old Stage Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruben — Middle: M. — Last: Alspaw
4. DATE OF DEATH: Month: 2 — Day: 23 — Year: 1967
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG 1, 1927
9. AGE (In years last birthday): 39 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN
10b. KIND OF BUSINESS OR INDUSTRY: TELEVISION
11. BIRTHPLACE (State or foreign country): COLUMBIA, MO.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: RUBEN MONTGOMERY ALSPAW
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): 2ND WORLD WAR
16. SOCIAL SECURITY NO.: 493-28-8875
17. INFORMANT: W.S. WHEELER, 1111 CAHEKON Rd ALEX. VA. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple injuries
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): driver in auto-auto collision
20c. TIME OF INJURY Month, Day, Year Hour: 5:20 p.m. 2 23 1967
20d. INJURY OCCURRED While at work ☒ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): street
20f. (City or town) (County) (State): Anne Arundel Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):
22. DATE SIGNED: 2/24/67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3-1-67
23c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med. School
23d. LOCATION (City or Town) (County) (State): Baltimore, Md.
24. FUNERAL DIRECTOR: Newell — ADDRESS

25a. REC'D BY REGISTRAR DATE: MAR 1 1967
25b. REGISTRAR'S SIGNATURE: Charles Yeager

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01614

CERTIFICATE OF DEATH

01611

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 715 Genessee St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Henry — Last: ARNOLD

4. DATE OF DEATH: Month: February — Day: 23 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 2, 1895

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER

10b. KIND OF BUSINESS OR INDUSTRY: SIGN Painting

11. BIRTHPLACE (County & State, or foreign country): BALTO. Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOHN H. ARNOLD

14. MOTHER'S MAIDEN NAME: JOHANNA L. EMMERICH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ANNE A. ARNOLD — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anemia
DUE TO (b): Chronic nephritis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
592X

INTERVAL BETWEEN ONSET AND DEATH: unknown / unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~XXXXXXX~~) attended the deceased from _____, 19____, to Feb. 22, 1967, that (I) (We) last saw the deceased alive on Feb. 22, 1967, and that death occurred at 2:55 AM, from causes and on the date stated above.

22a. SIGNATURE: Richard I. Hochman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/23/67

22c. PHYSICIAN'S NAME (Type): Richard I. Hochman, MD

22d. ADDRESS: ~~XXX XXXXXXXX XXXXX XXXXXXXXX, Md.~~ ~~XXXXXX~~ 67 Franklin St., Annapolis, Md.

23a. BURIAL, ~~CREMATION~~, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2-25-67

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest

23d. LOCATION (City or Town) (County) (State): Annapolis MD.

24. FUNERAL DIRECTOR: John M. Loyola & Son — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: FEB 28 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

Painter Sign Painting Radio
John H. Reubold Thomas L. Emmerich
r/o — Rose A. Reubold

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01615 01612

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Mayo (Edgewater)
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rt 1 Box 313 D

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Mayo (Edgewater) 02-1
   d. STREET ADDRESS: Rt 1 Box 313 D Edgewater
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: SADIE — Middle: FRANCES — Last: BALL

4. **DATE OF DEATH**: Month: Feb. — Day: 11 — Year: 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 28, 1890

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: never worked

11. BIRTHPLACE (County & State, or foreign country): Mayo, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: Willeminia Behlke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 214-05-2425D

17. INFORMANT: Mrs. Paul D. Spitnale-daughter — Address: same as #2 above

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	gen. Carcinomatosis	
DUE TO (b)	Ca of sigmoid	2 yrs.
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1533

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from jan, 19 55, to 2/11/67, 19, that (I) (~~saw~~) last saw the deceased alive on 2/10/67 19, and that death occurred at 5 P.M. from the causes and on the date stated above.

22a. SIGNATURE: S. Borssuck M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/13/67

22c. PHYSICIAN'S NAME (Type): S. Borssuck, M.D.,

22d. ADDRESS: Amos Garrett Blvd., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 14,1967

23c. NAME OF CEMETERY OR CREMATORY: Mayo Methodist Church

23d. LOCATION (City, town or county) (State): Mayo, Anne Arundel, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Beverley E. Hopping — ADDRESS: Hopping Funeral Home - Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: FEB 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A1S (4) 20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01616 — 01613

1. **PLACE OF DEATH**
a. COUNTY: AA — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Ferndale
c. LENGTH OF STAY IN 1b: 25 Yr -
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 106 - 1st Ave. - S. Ferndale

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~[illegible]~~ Ferndale
d. STREET ADDRESS: 106 First Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Elizabeth — Middle: Buckley — Last: Bamberger

4. **DATE OF DEATH**: Month: Dec. — Day: 10 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/19/82

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse & Saleslady

10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store

11. BIRTHPLACE (County & State, or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph W. Bamberger

14. MOTHER'S MAIDEN NAME: Va Poole

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 212-18-5095A

17. INFORMANT: Margaret Hudnall — Address: (sister) James as #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 Yr -
DUE TO (b): Diabetes - — 7 yr -
DUE TO (c):

260 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1950, to 3/10 19 67, that (I) (we) last saw the deceased alive on 2/10 19 67, and that death occured at 11 A.M, from the causes and on the date stated above.

22a. SIGNATURE: Chas. L. Ball Jr. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/10/67

22c. PHYSICIAN'S NAME (Type): Charles L. Ball Jr.

22d. ADDRESS: Linthicum, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 13, 67

23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Park

23d. LOCATION (City, town or county) (State): Howard Co., Elkridge, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Eugene B. Fleming — ADDRESS: Singleton Funeral Home, Glen Burnie, Maryland

25a. REC'D BY REGISTRAR DATE: FEB 14

25b. REGISTRAR'S SIGNATURE: 1967 Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

01617

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

Items 3 & 14 Film G 386
2/28/67 jml

01614

1. PLACE OF DEATH
a. COUNTY A. A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Md. 02-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 713 Carolyn Rd.
d. STREET ADDRESS 713 Carolyn Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Raymond Middle Benzinger Last
4. DATE OF DEATH Month Feb. Day 17, Year 1967

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 10/7/06
9. AGE (In years last birthday) 60 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter
10b. KIND OF BUSINESS OR INDUSTRY Hanline Bros.
11. BIRTHPLACE (County & State, or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME David Bensinger
14. MOTHER'S MAIDEN NAME Kate Meekin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. II
16. SOCIAL SECURITY NO. 215-05-9063
17. INFORMANT Address: Glen Burnie, Md. Elsie E. Bensinger, 713 Carolyn Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
163X
IMMEDIATE CAUSE (a) Carcinoma of Lung
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 1966, to Feb 17, 1967, that (I) (we) last saw the deceased alive on 2/8 1967, and that death occurred at 6A M, from causes and on the date stated above.

22a. SIGNATURE Joseph Taler, M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 2/17/67
22c. PHYSICIAN'S NAME (Type) JOSEPH TALER
22d. ADDRESS Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 2/20/67
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.

24. FUNERAL DIRECTOR HOWARD H. HUBBARD, ~~Alex~~ ADDRESS 4107 Wilkens Ave. 21229
25a. REC'D BY REGISTRAR DATE FEB 24 1967
25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01618

CERTIFICATE OF DEATH

01615

PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - GLEN BURNIE
c. LENGTH OF STAY IN 1b: 13 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NORTH ARUNDEL GENERAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): RURAL - PASADENA
d. STREET ADDRESS: 232 GRANDVIEW RD. LONG POINT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
FREDERICK		BERGER	FEBRUARY	10	1967

5 SEX	6 COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
MALE	WHITE		AUGUST 7, 1907	59 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
CHAUFFEUR	DEPT. of SANTITATION	MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Christian Berger	Mamie Downing

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17 INFORMANT	Address
NO None	212-10-5779	Helen Berger 232 Grandview Rd.	Long Point, M

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Metastatic Carcinoma	
DUE TO (b)	Carcinum Lung	
DUE TO (c)		

163X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			

21. I **certify** that (I) (this hospital) attended the deceased from _____, 19__ to February 10, 1967 that (I) (we) last saw the deceased alive on February 1, 1967, and that death occurred at 10 ~~PM~~ AM, from causes and on the date stated above.

22a SIGNATURE	M.D.	ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐	22b. DATE SIGNED
J. B. RAMIREZ			2/10/67

22c PHYSICIAN'S NAME (Type)	22d. ADDRESS
J. B. RAMIREZ	3527 ANNAPOLIS RD Balto 27 1672 NORTH BOURNE RD Balto 12

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	2/14/67	Oak Lawn	7225 Eastern Ave Balto. Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Frederick D. Miller Inc	3019 E. Monument St	FEB 14 1967	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01619

CERTIFICATE OF DEATH

01616

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: 36 yrs. 2 mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Children's Center Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C.
d. STREET ADDRESS: 1018 Potomac Avenue, S. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Irene — Middle — Last: Berry

4. DATE OF DEATH: Month: February — Day: 7, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-19-94

9. AGE (In years Last birthday): 72 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Institutionalized

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: ~~Children's Center Hospital, Laurel, Md.~~

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Intestinal obstruction with marked gastric ~~dilation and diffused gastric hemorrhage~~ — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): Mental retardation
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 1, 1930, to Feb. 7, 1967, that (I) (we) last saw the deceased alive on Feb. 7 1967, and that death occurred at 10:20 A.M., from causes and on the date stated above.

22a. SIGNATURE: George T. Economos M.D. — ATTENDING PHYS ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 2/9/67

22c. PHYSICIAN'S NAME (Type): GEORGE T. ECONOMOS, M. D.

22d. ADDRESS: Children's Center Hospital, Laurel, Md.

23a. BURIAL, CREMATION, ~~REMOVAL~~ (Specify)

23b. DATE THEREOF: 2/10/67

23c. NAME OF CEMETERY OR CREMATORY: Children's Center

23d. LOCATION (City or Town): Laurel (County): A. A. (State): Md.

24. FUNERAL DIRECTOR: Willett Davidson ADDRESS: Laurel Md.

25a. REC'D BY REGISTRAR DATE: FEB 15 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01620 01617

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): JESSUP
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): US HIGHWAY 32 NEAR JESSUP, MD

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: NORTH DAKOTA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SE MINOT
d. STREET ADDRESS: 108 . 19TH STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FABIAN — Middle NMI — Last BLACK JR.

4. DATE OF DEATH: Month FEBRUARY — Day 4 — Year 19 67

5. SEX: MALE

6. COLOR OR RACE: CAU

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 18 APRIL 1943

9. AGE (In years last birthday): 23 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SOLDIER

10b. KIND OF BUSINESS OR INDUSTRY: US ARMY

11. BIRTHPLACE (County & State, or foreign country): RUGLY, ND

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: FABIAN BLACK SR.

14. MOTHER'S MAIDEN NAME: LENA KRUTZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): YES — MAR 66-4 FEB 67

16. SOCIAL SECURITY NO.: 502-48-0067

17. INFORMANT: FABIAN BLACK SR(F) — Address: 108 19TH STREET SE MINOT, ND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Basilar Skull Fracture, Laceration(R) Lung and
DUE TO (b): Liver
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto Accident

20c. TIME OF INJURY: Hour 1:30 a.m. p.m. — Month, Day, Year: Feb 4 1967

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt # 32

20f. (City or town) (County) (State): Near Jessup(Anne Arundel) Md.

21. I certify that [illegible] the deceased [illegible] Was DOA [illegible] 4 Feb, 1967, [illegible] and that death occurred at 1:50 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Capt Felix A Conte MC

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 4 February 1967

22c. PHYSICIAN'S NAME (Type): FELIX A. CONTE, CPT, MC

22d. ADDRESS: KIMBROUGH AH, FT GEO G MEADE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Feb.9,1967

23c. NAME OF CEMETERY OR CREMATORY: ROSEHILL CEMETERY

23d. LOCATION (City, town or county) (State): MINOT, NORTH DAKOTA

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Harold S. Wade, 550 Wash. Blvd., Laurel, Marylane

25a. REC'D BY REGISTRAR DATE: FEB 8 1967

25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4)
20M 5-63

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01621

CERTIFICATE OF DEATH

01618

1 PLACE OF DEATH
a COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c LENGTH OF STAY IN 1b: 6 weeks

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Md. — b COUNTY: Baltimore
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d STREET ADDRESS (Exact): Box 264, Rt 2, Pasadena, Md
e IS RESIDENCE ON A FARM? YES ☐ NO ☑

d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Annapolis Nursing and Convalescent Home

3 NAME OF DECEASED (Type or print): First: ANNA — Middle: E. — Last: BOESSER

4 DATE OF DEATH: Month: 2 — Day: 6 — Year: 1967

5 SEX: female

6 COLOR OR RACE: white

7 MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 11-26-79

9 AGE (In years last birthday): 87 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State or foreign country): Baltimore, Md

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? BOESSER

14. MOTHER'S MAIDEN NAME: UNKNOWN

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):

16 SOCIAL SECURITY NO: 215-10-3802

17 INFORMANT: Roger T. Bollman — Address: Box 264, Pasadena, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Left lower lobe Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
4221
DUE TO (b): Congestive Heart failure — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): Art. sclero cardio vas. disease — years?

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes, mellitus; Cysto-pyelitis; Senility.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from Dec. 15, 1966, to Feb. 6, 1967, that (I) (~~we~~) last saw the deceased alive on Feb. 5 1967, and that death occurred at 9.20 A.M., from causes and on the date stated above

22a SIGNATURE: Peter F. Verkouw — M.D. — ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 2-6-67

22c. PHYSICIAN'S NAME (Type): PETER F. VERKOUW

22d ADDRESS: 1407 FOREST DR. ANNAPOLIS, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: 2/9/1967

23c. NAME OF CEMETERY OR CREMATORY: MORELAND MEMORIAL

23d LOCATION (City or Town) (County) (State): BALTO MARYLAND

24 FUNERAL DIRECTOR — ADDRESS: WEBER FUNERAL HOME 5311 EDMONDSON AVE.

25a RECD BY REGISTRAR — DATE: FEB 8 1967

25b REGISTRAR'S SIGNATURE

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01622 — 01619

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN this: 7 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 309 Third Ave. S. W.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 309 Third Ave. S. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Douglas		Bowen	Feb.	23.	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White		26 Aug. 1888	78 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Telegrapher	Penna. RR	Charles County, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Bowen	Virginia Kohler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	16. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Address
Yes	WW 1	Mrs. Alice Cowan Bowen, same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Cardiac Standstill — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Myocardial Infarction

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerotic Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. / Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 19 50, to Feb 23, 19 67, that (I) (we) last saw the deceased alive on Feb 22 19 67, and that death occurred at 2:50 P.M., from the causes and on the date stated above.

22a. SIGNATURE M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
Benjamin Berdann		

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Benjamin Berdann, M. D.	5010 Ritchie Highway, Baltimore 25, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	27 Feb. 67	Glen Haven Memorial	Glen Burnie, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Kirkley Funeral Home, Glen Burnie, Md.	FEB 27 1967	Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01623 — 01620

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7161

1. **PLACE OF DEATH**
a. COUNTY: A. A.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shadyside
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If institution, residence before admission)
a. STATE: Md.
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shadyside
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Hazell Middle: B. Last: Brooks

4. **DATE OF DEATH**: Month: 2 Day: 28 Year: 1967

5. SEX: Female

6. COLOR OR RACE: Col

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-25-1891

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: House Wife

11. BIRTHPLACE (County & State or foreign country): D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Dixon

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Bladder — INTERVAL BETWEEN ONSET AND DEATH: one year
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan ....., 1966, to Feb 28 ....., 1967, that (I) (we) last saw the deceased alive on Feb 24 ....., 1967, and that death occured at 2 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Willard F Smith MD M.D.

22b. DATE SIGNED: 3/4/67

22c. PHYSICIAN'S NAME (Type): Willard F. Smith, MD

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-4-1967

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven

23d. LOCATION (City, town or county): Deal

(State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: William Reese

ADDRESS: Anna, Md.

25a. REC'D BY REGISTRAR DATE: MAR 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01624

CERTIFICATE OF DEATH

01621

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel County — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Glen Burnie, Md.
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): North ~~Arnudel~~ Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Box 237, Elkridge 27, Md.
   d. STREET ADDRESS: ~~Hospital Drive~~ Glen Burnie, Md. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: M. — Last: Buchanan

4. DATE OF DEATH: Month: Feb. — Day: 14 — Year: 1967

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-30-24

9. AGE (In years last birthday): 42 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction Foreman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Alabama

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Frank M. Buchanan

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: 21227: Mrs. Lorraine Buchanan-Box 237, Elkridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of the Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs

10%

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from September, 1965, to Febry 14, 1967, that (I) (we) last saw the deceased alive on February 14 1967, and that death occurred at 12:20 P M, from the causes and on the date stated above.

22a. SIGNATURE: E. Roderick Shipley — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: February 14, 1967

22c. PHYSICIAN'S NAME (Type): E. Roderick Shipley

22d. ADDRESS: 529 Camp Meade Rd, Linthicum Hts. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-17-67

23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Memorial Park

23d. LOCATION (City, town or county) (State): Dorsey Road Howard County, Md.

24. FUNERAL DIRECTOR — ADDRESS: Howard H. Hubbard-4107 Wilkens Ave. 21229

25a. REC'D BY REGISTRAR — DATE: FEB 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01625

CERTIFICATE OF DEATH

01622

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 5955 Pinewood Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: BUNN

4. DATE OF DEATH: Month: February — Day: 26 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 26, 1967

9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): newborn

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Doyet E. Bunn

14. MOTHER'S MAIDEN NAME: Elizabeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: nonen

17. INFORMANT: Doyet E. Bunn same as #2 above — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 5 hr.
DUE TO (b): Placental insufficiency
DUE TO (c): Placental anomaly
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7735

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from _____, 19 ___, to _____, 19___, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at 9:15 P.M. from causes and on the date stated above

22a. SIGNATURE: Joseph C Sheehan M.D — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Joseph C. Sheehan M. D.

22d. ADDRESS: 208 West Street, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 28, 1967

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

23d. LOCATION (City or Town) (County) (State): Annapolis, A.A. Md.

24. FUNERAL DIRECTOR: Beverley L. Hopping — ADDRESS: Hopping Funeral Home, Annapolis, Maryland

25a. REC'D BY REGISTRAR DATE: FEB 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01626 01623

1. PLACE OF DEATH
a. COUNTY A. A. Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Howard
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mercy Hospital Woodlawn Md

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE MD b. COUNTY A A Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park — 21146
d. STREET ADDRESS 827 Cottonwood Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Lela Middle B. Last Burkhardt

4. DATE OF DEATH Month 2-13-67 Day Year 19

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Sept 23, 1886
9. AGE (In years last birthday) 80 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (County & State, or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Henry J. Beck
14. MOTHER'S MAIDEN NAME Elizabeth Weaver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address D. H. Burkhardt - 827 Cottonwood Dr 21146

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia & General Debility Precipitated by Acute Pulmonary Edema
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) Secondary to Senility
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH Months Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1967, 19__ to 1967, 19__, that (I) (we) last saw the deceased alive on 2-8-67, 19__, and that death occurred at 9:55 M, from the causes and on the date stated above.

22a. SIGNATURE Robert R Hahn M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 2-13-67
22c. PHYSICIAN'S NAME (Type) Robert R. HAHN
22d. ADDRESS P.O. Box 73 Severna Park

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 2-16-1967
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery
23d. LOCATION (City, town or county) (State) Elkridge - Howard Co - Md

24. FUNERAL DIRECTOR ADDRESS Edward A. MacNabb Jr. 301 Frederick Rd - 28
25a. REC'D BY REGISTRAR DATE FEB 15 1967
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01627 — 01624

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G MEADE
c. LENGTH OF STAY IN 1b: 45 Min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CROWNSVILLE
d. STREET ADDRESS: St. STEVENS ROAD Rt. #1 Box #77 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First THOMAS — Middle EDWARD — Last Sr. CAMPBELL

4. **DATE OF DEATH**: Month February — Day 13 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: CAUC

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 18 Dec 1899

9. AGE (In years last birthday): ~~68~~ 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Serviceman

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Army

11. BIRTHPLACE (County & State, or foreign country): Omar, W. Va.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ~~Unknown~~ Thomas Campbell

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Matilda C. Laposki

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give wer or dates of service): 1918-1948

16. SOCIAL SECURITY NO.: 219-28-0757

17. INFORMANT (son-in-law) Address: Thomas D. Hope, Cecil Ave, Millersville, Md

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from 12 Feb 1967 to 13 Feb 1967, that ☒ (we) last saw the deceased alive on 13 Feb 1967, and that death occurred at 12:40 a.m. from the causes and on the date stated above

22a. SIGNATURE: Burton A. Johnson, MD — M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED: 13 Feb 67

22c. PHYSICIAN'S NAME (Type): BURTON A. JOHNSON, MC, CPT

22d. ADDRESS: KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 15, 1967

23c. NAME OF CEMETERY OR CREMATORY: Our Lady of the Field

23d. LOCATION (City, town or county) (State): Millersville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Eugene B. Flemings — ADDRESS: Singleton Funeral Home, Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: FEB 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A1S (4) 20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01628

CERTIFICATE OF DEATH

01625

1 PLACE OF DEATH
a COUNTY: A.A. Co. — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WARDOUR
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ALDEN LANE

2 USUAL RESIDENCE (Where deceased lived, if inst tut on Resident refer to admission)
a STATE: MD. — b COUNTY: A.A. Co.
c CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town): WARDOUR
d STREET ADDRESS: ALDEN LANE
e IS RES DENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ANNA Middle MARIE Last CARTER
4 DATE OF DEATH: Month 2 Day 13 Year 1967

5 SEX: f
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 8-18-1894
9 AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME
10b KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE
11 BIRTHPLACE (County & State or foreign country): ANNAPOLIS, MD.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: L. PETER CARLSON
14 MOTHER'S MAIDEN NAME: KATHERINA JENSEN

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):
16 SOCIAL SECURITY NO:
17 INFORMANT: ELIZABETH C. TATE — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO (b): Coronary artery insufficiency & sclerosis — 10 yrs.
DUE TO (c):
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1956, to Dec., 1967, that (I) (we) last saw the deceased alive on 2/12/1967, and that death occurred at 4:30 P.M. from causes and on the date stated above.

22a SIGNATURE: John Hederman M.D. — ATTENDING PHYS ☑ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 2/17/67
22c PHYSICIAN'S NAME (Type): John Hederman
22d ADDRESS: Forest Dr. Annapolis, Md.

23a BURIAL, ~~CREMATION~~, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 2-15-67
23c NAME OF CEMETERY OR CREMATORY: CEDAR Bluff
23d LOCATION (City or Town) (County) (State): ANNAPOLIS A.A. MD.

24 FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: FEB 16 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01629 01626

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G MEADE
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G MEADE
d. STREET ADDRESS: 7905-B JENNINGS COURT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: KIRBY — Middle: DOUGLAS — Last: CASE

4. DATE OF DEATH: Month: FEBRUARY — Day: 20 — Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: CAU

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 1 NOV 1958

9. AGE (In years last birthday): 8 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: N/A

11. BIRTHPLACE (County & State, or foreign country): GULFPORT, MISS

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: CALVIN CASE, JR.

14. MOTHER'S MAIDEN NAME: SHIRLEY A. RICHARDSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: N/A

17. INFORMANT (father) Address: Calvin Case, Jr. 7905-B Jennings Ct, FGGM, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): GUN SHOT WOUND OF CHEST — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MED.CAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of Item 18.): Patient shot in chest

20c. TIME OF INJURY: Hour 4:20 p.m. — Month, Day, Year: 20 Feb 1967

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): House

20f. (City or town) (County) (State): Ft Geo G Meade Anne Arundel Md.

21. **I certify** that (I) (this hospital) attended the deceased from WAS DOA, 19, to 20 Feb, 1967, that I (last) saw the deceased alive on 19, and that death occurred at 4:20 p.m., from the causes and on the date stated above.

22a. SIGNATURE: Harold T. Becher M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 20 FEB 67

22c. PHYSICIAN'S NAME (Type): HAROLD T. BECHER, CPT, MC

22d. ADDRESS: KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Feb. 24, 1967

23c. NAME OF CEMETERY OR CREMATORY: PLEASANT GROVE CEMETERY,

23d. LOCATION (City, town or county) (State): BROOKHAVEN, MISSIPPI, LINCOLN CO

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Harold S. WAde, 550 Wash. Blvd, Laurel, Maryland

25a. REC'D BY REGISTRAR DATE: FEB 24 [illegible]

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01630

CERTIFICATE OF DEATH

01627

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hunter's Harbor
c. LENGTH OF STAY IN 1b: 24 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): none. 1416 Peace Dr.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena, Md.
d. STREET ADDRESS: Hunter's Harbor 1416 Peace Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Leo — Last: Chance
4. DATE OF DEATH: Month: February — Day: 1 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 17, 1915
9. AGE (In years last birthday): 51 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lithographer
10b. KIND OF BUSINESS OR INDUSTRY: Printing
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Chance
14. MOTHER'S MAIDEN NAME: Bertha Geary
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes — (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 217-09-0541
17. INFORMANT: Mrs. James Leo Chance — Address: Pasadena, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of the urinary bladder — INTERVAL BETWEEN ONSET AND DEATH: 1 year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from July 1, 1965, to Feb 1, 1967, that (I) (~~we~~) last saw the deceased alive on Jan. 30 1967, and that death occurred at 7:7 M, from the causes and on the date stated above.

22a. SIGNATURE: R. W. McLaughlin — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/1/67
22c. PHYSICIAN'S NAME (Type): R. W. McLaughlin
22d. ADDRESS: 3708 Mountain Rd. Pasadena, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-3-67
23c. NAME OF CEMETERY OR CREMATORY: Pasadena National
23d. LOCATION (City, town or county) (State): Pasadena Md.

24. FUNERAL DIRECTOR: Robert A. Bonanni — ADDRESS: Severna Pk. Md.
25a. REC'D BY REGISTRAR DATE: FEB 3 1967
25b. REGISTRAR'S SIGNATURE: Charles Snyder

VR A15 (4)
15M 4-64

4 1 (M)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01631

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01628

1 PLACE OF DEATH
a. COUNTY: A.A.Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. - NOR. Th. ARUNDEL - GEN.

2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: MD — b. COUNTY: A.A.Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEVERN
d. STREET ADDRESS: Rt 193 - Burns Crossing Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Daisy — Middle: V — Last: Chase

4 DATE OF DEATH: Month: 2 — Day: 2 — Year: 1967

5 SEX: F

6 COLOR OR RACE: W

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Aug 15 1886

9 AGE (In years last birthday): 80 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b KIND OF BUSINESS OR INDUSTRY: Own Home

11 BIRTHPLACE (State or foreign country): Bethel, Ohio

12 CITIZEN OF WHAT COUNTRY: U.S.A.

13 FATHER'S NAME: Samuel Campbell

14 MOTHER'S MAIDEN NAME: UNKNOWN

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): NO (If yes give war or dates of service)

16 SOCIAL SECURITY NO: 214-46-2963

17 INFORMANT: Melvin L. Chase — Address: Sp Mo aa Rt 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Gen. Sclerosis and Chest — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
176X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Self inflicted gunshot wound

20c TIME OF INJURY Month, Day, Year: Hour 1:30 p.m. — 2/2 1967

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f (City or town): A.A.Co (County): MD (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): F. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 2/2/67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-6-1967

23c. NAME OF CEMETERY OR CREMATORY: O/L Bethel Cemetery

23d LOCATION (City or Town) (County) (State): Fort Meade A.A.Co. Md.

24 FUNERAL DIRECTOR: Robert Burns — ADDRESS: Singleton Funeral Home, Glen Burnie, Md.

25a REC'D BY REGISTRAR DATE: FEB 10 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

VR A15 (4)
20 M 3/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01632

CERTIFICATE OF DEATH

01629

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL CO. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE
c. LENGTH OF STAY IN 1b: //////
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD. — b. COUNTY: A.A. CO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: N/W #104 Balto. & Annapolis Blvd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ALBERT — Middle FRANK — Last CLAUSS

4. DATE OF DEATH: Month FEB. — Day 8th — Year 19 67

5 SEX: MALE

6 COLOR OR RACE: W.

7 MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 9-15-98

9 AGE (In years last birthday): 68 yrs — IF UNDER 1 YEAR: Months 9 Days 7 — IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self-employed

10b KIND OF BUSINESS OR INDUSTRY: CLAUSS CLOTHING STORE GLEN BURNIE

11 BIRTHPLACE (County & State, or foreign country): Glen Burnie, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: William H.S. Clauss

14. MOTHER'S MAIDEN NAME: Clara B. Blaustimer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 219-32-1859

17 INFORMANT: Address: Mrs. Viola G. Clauss (wife) Same as #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: months
DUE TO (b): Arteriosclerotic Heart Disease — years
DUE TO (c):
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from _____, 1963 to Feb -, 1967, that (I) (we) last saw the deceased alive on Jan 1967, and that death occurred at 7:20 P.M. from causes and on the date stated above.

22a. SIGNATURE: Hilary T. McHenry — M.D — ATTENDING PHYS ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 2-8-67

22c PHYSICIAN'S NAME (Type): Hilary T. McHenry M.D.

22d. ADDRESS: 5 Central Ave. Glen Burnie, Md

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: Feb.11,1967

23c NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Md.

24 FUNERAL DIRECTOR: Richard V. Singleton — ADDRESS: Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: FEB 14 1967

25b REGISTRAR'S SIGNATURE: [illegible] Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01633

CERTIFICATE OF DEATH

01630

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie 21061
d. STREET ADDRESS: 105 M. St. [redacted]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): [redacted] JEANNETTE COHN
4. DATE OF DEATH: Month February Day 16 Year 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: October 13, 188[5]
9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (County & State, or foreign country): France
12. CITIZEN OF WHAT COUNTRY? ?

13. FATHER'S NAME: Joseph Oppenheimer
14. MOTHER'S MAIDEN NAME: Juliette Marmelstein

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT — Address: Mr. Rudolph Cohn, 8 Oak Lane, S. W. Glen Burnie

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lymphoma, Malignant
DUE TO (b): type?
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
2002
INTERVAL BETWEEN ONSET AND DEATH: 1+ yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-14-67 to 2-16-67, that (I) (we) last saw the deceased alive on February 16, 1967, and that death occurred at 11:55 A.M. from causes and on the date stated above

22a. SIGNATURE: Frank McSherry M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-16-67
22c. PHYSICIAN'S NAME (Type): FM SHIPLEY
22d. ADDRESS: ANNAPOLIS MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/17/67
23c. NAME OF CEMETERY OR CREMATORY: Har Sinai (Old)
23d. LOCATION (City or Town) (County) (State): Baltimore MD

24. FUNERAL DIRECTOR — ADDRESS: Sol Levinson & Bros. Inc., 6010 Reisterstown
25a. REC'D BY REGISTRAR — DATE: FEB 23 1967
25b. REGISTRAR'S SIGNATURE: J Charles Jenkins

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01634

CERTIFICATE OF DEATH

01631

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 12 Maryland Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Patrick — Last: CONNOLLY
4. DATE OF DEATH: Month: February — Day: 8 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 10, 1902
9. AGE (In years last birthday): 64
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - newspaperman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John T. Connolly
14. MOTHER'S MAIDEN NAME: Catherine V. McDermott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None
16. SOCIAL SECURITY NO: 213-03-2952
17. INFORMANT: Mrs. Audrey Connolly — Address: same address as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma of hypopharynx — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b): Dysphagia for months. — ?
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this physician) attended the deceased from Jan 2 '67, 19__, to Feb. 8, 19 67 that (I) (he) last saw the deceased alive on Feb. 8, 19 67, and that death occurred at 10:00 AM, from causes and on the date stated above.

22a. SIGNATURE: General Electric — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2/8/67
22c. PHYSICIAN'S NAME (Type): Gorman Clinic
22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 2/10/1967
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City or Town) (County) (State): Williamport, Pennsylvania

24. FUNERAL DIRECTOR: Wm. J. Tichnell Sons — ADDRESS: Baltimore Md. & Pa. Ave.
25a. RECD BY REGISTRAR DATE: FEB 10 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01635

CERTIFICATE OF DEATH

01632

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riviera Beach
d. STREET ADDRESS: 1164 Easport Terranc
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) #34590 — First: John — Middle: W. — Last: Cooper

4 DATE OF DEATH — Month: 2 — Day: 17 — Year: 19 67

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: 3/11/1885

9. AGE (In years last birthday): 81 yrs

IF UNDER 1 YEAR — Months: — Days:
IF UNDER 24 HRS — Hours: — Min.:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plasterer

10b KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter Cooper

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-03-6993

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremic Dehydration
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Arterio sclerotic Cardiovascular Renal Disease
DUE TO
(c): ----------

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Cerebral Arteriosclerosis - Hypostatic pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19--

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/11/, 1967, to 2/17/, 1967, that (I) (we) last saw the deceased alive on 2/17/, 19 67, and that death occurred at 12:40 M, from causes and on the date stated above.

22a. SIGNATURE: Lionel McHenry Mapp M.D. — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2/17/67

22c. PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M.D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/20/67

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR: Singleton Funeral Home/Glen Burnie, Md.
ADDRESS: Robert Pearce

25a. REC'D BY REGISTRAR DATE: FEB 20 1967

25b. REGISTRAR'S SIGNATURE: Charles Just

1 B

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01636

CERTIFICATE OF DEATH

01633

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundle Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 401 Old Annapolis Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First BENJAMIN Middle FRANKLIN Last CRISP

4. DATE OF DEATH: Month FEBRUARY Day 24 Year 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 17, 1910

9. AGE (In years last birthday): 56 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Crisp

14. MOTHER'S MAIDEN NAME: Marguerite Broughon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs. Virginia Crisp — Address: 401 Old Annapolis Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma
DUE TO (b): Bronchogenic Carcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 6 MONTHS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19 6[illegible], to Feb., 19 67, that (I) (we) last saw the deceased alive on Jan. 19 67, and that death occurred at 6 A.M., from causes and on the date stated above.

22a. SIGNATURE: Aidan E. Walsh — M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2.27.67

22c. PHYSICIAN'S NAME (Type): AIDAN E. WALSH

22d. ADDRESS: 715 N. CHARLES

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-28-1967

23c. NAME OF CEMETERY OR CREMATORY: Oak Lawn

23d. LOCATION (City or Town) (County) (State): Baltimore County, Maryland

24. FUNERAL DIRECTOR: Lilly & Zeiler Inc. — ADDRESS: 1901-07 Eastern Ave.

25a. REC'D BY REGISTRAR DATE: FEB 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

. DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01638 — 01635

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M 5-63

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Knollwood Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
d. STREET ADDRESS: 39 Danza Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward; Middle: D.; Last: Cronin

4. DATE OF DEATH: Month: Feb.; Day: 25; Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: June 11, 1876

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stationary Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Unknown Cronin

14. MOTHER'S MAIDEN NAME: Bridget Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Richard Fahr — Address: 39 Danza Rd.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Gastroenterinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: few hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): pt Pyloric ulcer of stomach
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive heart failure - Osteoarthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCR BE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (i) (this hospital) attended the deceased from 1/25, 1967 to 2/25, 1967, that (I) ~~(we)~~ last saw the deceased alive on 2/21, 1967, and that death occurred at 12:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: K M Smith M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/25/67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2 28 67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
23d. LOCATION (City, town or county) (State): Balto. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: c Cully
ADDRESS: 130 S. Fort Ave

25a. REC'D BY REGISTRAR DATE: FEB 27 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01637

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01634

1 PLACE OF DEATH
a COUNTY A.A. Co. MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c LENGTH OF STAY IN 1b
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Anne Arundel Gen.

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a STATE MD b COUNTY AA Co.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
d STREET ADDRESS South Haven Rd.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Jeffrey Middle N Last Crutchley
4 DATE OF DEATH Month ✓ Day 13 Year 1967

5 SEX M
6 COLOR OR RACE W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH 10-20-66
9 AGE (In years last birthday) yrs
IF UNDER 1 YEAR Months 4 Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) Annapolis
12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME Robert Munroe Crutchley
14 MOTHER'S MAIDEN NAME Nancy Haskett Crutchley

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)
16 SOCIAL SECURITY NO
17 INFORMANT Address South Haven.
Mr. Robert Munroe Crutchley Anna.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Acute hypostatic pneumonia Infection — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE _____ M.D
EXAMINER'S NAME (Type) F. Linhardt.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED 2/13/67

23a BURIAL, CREMATION, REMOVAL (Specify) Burial
23b DATE THEREOF Feb. 15 1967
23c NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
23d LOCATION (City or Town) Annapolis, Md. (County) (State)

24 FUNERAL DIRECTOR Robert S. Beall Jr.
ADDRESS BEALL FUNERAL HOME 1212 West St., Anna
25a RECD BY REGISTRAR DATE FEB 16 1967
25b REGISTRAR'S SIGNATURE J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01639

01636

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Anne Arundel	b. STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town): Annapolis	c. LENGTH OF STAY IN 1b: D. O. A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel County Hospital	
2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland	b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Davidsonville	
d. STREET ADDRESS: Four Rivers Farm	e. IS RESIDENCE ON A FARM? YES ☒ NO ☐
3. NAME OF DECEASED (Type or print): First: Robert; Middle: Lee; Last: Daly	4. DATE OF DEATH: Month: February; Day: 26; Year: 19 67
5. SEX: Male	6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: May 26, 1909
9. AGE (In years last birthday): 57 yrs	IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Builder & Developer	10b. KIND OF BUSINESS OR INDUSTRY: Self employed
11. BIRTHPLACE (County & State, or foreign country): New Orleans, Louisiana	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown	14. MOTHER'S MAIDEN NAME: (Unknown) Mc Conchie
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) None	16. SOCIAL SECURITY NO. Yes
17. INFORMANT: Dorothy M. Daly	Address: Four Rivers Farm Davidsonville, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate

DUE TO (b): Atherosclerotic Heart Disease — Unknown

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) ~~(this hospital)~~ attended the deceased from ____, 1965, to 2/26, 1967, that (I) ~~(we)~~ last saw the deceased alive on 12 1966, and that death occurred at ~~12:22 A.M.~~, from causes and on the date stated above

22a. SIGNATURE: Richard I. Hochman M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 2/26/67

22c. PHYSICIAN'S NAME (Type): Richard I. Hochman, M.D.

22d. ADDRESS: 59 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: March 1, 1967	23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State): Prince Georges Co., Md.	
24. FUNERAL DIRECTOR: Glen Carter for Warner E. Pumphrey, Inc.	ADDRESS: 8434 Georgia Ave. Silver Spring, Md.	25a. REC'D BY REGISTRAR DATE: MAR 3 1967	25b. REGISTRAR'S SIGNATURE: Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01640 — 01637

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a COUNTY: AA CO — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.H - Anne Arundel General

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: MD — b COUNTY: AA CO
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Weems Creek, Annapolis
d STREET ADDRESS: Lake Creek Drive
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Charles — Middle: W. — Last: DAVIS

4 DATE OF DEATH: Month: 2 — Day: 28 — Year: 19 67

5 SEX: M

6 COLOR OR RACE: W

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 12-24-14

9 AGE (In years last birthday): 52 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Roofer

10b KIND OF BUSINESS OR INDUSTRY: Self - emp.

11 BIRTHPLACE (State or foreign country): Baltimore, Md.

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Charles E. Davis

14 MOTHER'S MAIDEN NAME: Margaret L. Prince

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16 SOCIAL SECURITY NO: 217 - 07 - 6413

17 INFORMANT Address: Mrs. Loretta Davis, same as 2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Gun Shot - wound - Chest
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Self inflicted shot gun wound chest

20c TIME OF INJURY Month Day, Year Hour a.m. p.m. 2/28 1967

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f (City or town) AACO (County) MD (State)

21 **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E Linhardt M.D
EXAMINER'S NAME (Type): F. Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22 DATE SIGNED: 2/28/67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 2 March 67
23c NAME OF CEMETERY OR CREMATORY: Holly Hill
23d LOCATION (City or Town) (County) (State): Essex, Md.

24 FUNERAL DIRECTOR ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.

25a RECD BY REGISTRAR DATE: MAR 3 1967
25b REGISTRAR'S SIGNATURE: J Cleveland Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01641

CERTIFICATE OF DEATH

01638

1. PLACE OF DEATH
a. COUNTY: A.A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shadyside
c. LENGTH OF STAY IN 1b: 11 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shadyside
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PRYNSE Middle XAVIER Last Davis

4. DATE OF DEATH: Month February Day 16 Year 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-31-94
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Printer
10b. KIND OF BUSINESS OR INDUSTRY: Govt & Private
11. BIRTHPLACE (County & State, or foreign country): St Louis Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 212 24 4343
17. INFORMANT: Address: A Mrs Caryl E. Bittle, Shadyside Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Immediate
4201
DUE TO (b): Coronary atherosclerosis — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1962, to Feb 16, 1967, that (I) (we) last saw the deceased alive on Dec 1966, and that death occurred at 8:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/17/67
22c. PHYSICIAN'S NAME (Type): Willard F. Smith, MD
22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb 20 1967
23c. NAME OF CEMETERY OR CREMATORY: Evergreen
23d. LOCATION (City or Town) (County) (State): Bladensburg P.G. Md.

24. FUNERAL DIRECTOR: Bernard Hardesty ADDRESS: Edelville Md.
25a. REC'D BY REGISTRAR DATE: Feb 28 1967
25b. REGISTRAR'S SIGNATURE: J Clarke

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01642 01639

1 PLACE OF DEATH
a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 mo. 15 da.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, f institution residence before admission)
a. STATE: Maryland b. COUNTY: Anne Arundel
c CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town): Shady Side
d. STREET ADDRESS:
e S RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Nebraska Middle (none) Last DENNIS
4. DATE OF DEATH: Month February Day 19 Year 1967
5 SEX: Male
6 COLOR OR RACE: Negro
7 MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 17, 1892
9 AGE (In years last birthday) 74 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Edward Dennis
14 MOTHER'S MAIDEN NAME: Jenns Donell
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): yes WWI
16 SOCIAL SECURITY NO: 218-46-3524
17. INFORMANT: Edward Dennis Address: Shadyside

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY-
IMMEDIATE CAUSE (a): Pneumonia & bronchial pulmonary embolism
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arterio sclerosis, coronary thrombosis, congestive heart failure
19 WAS AUTOPSY PERFORMED? YES ☐ NO XX

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) attended the deceased from _____, 19____, to Feb. 19, 1967, that (I) last saw the deceased alive on Feb. 19 19 67, and that death occurred at 3:00 PM M, from causes and on the date stated above.

22a. SIGNATURE: R. Brem M.D. ATTENDING PHYS XX MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 2/22/67
22c. PHYSICIAN'S NAME (Type): R Brem
22d ADDRESS: 121 Cathedral St., Annapolis, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 2-23-1967
23c NAME OF CEMETERY OR CREMATORY: St. Mathews
23d LOCATION (City or Town) (County) (State): Shadyside Md
24 FUNERAL DIRECTOR ADDRESS: William Reese Annapolis Md
25a REC'D BY REGISTRAR DATE: FEB 24 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01643 — 01640

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 112 South St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: (none) — Last: DILLARD

4. DATE OF DEATH: Month: February — Day: 1 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 22, 1892
9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supply Dept
10b. KIND OF BUSINESS OR INDUSTRY: **********
11. BIRTHPLACE (County & State, or foreign country): A.A.Co Maryland
12. CITIZEN OF WHAT COUNTRY? U.S. A.

13. FATHER'S NAME: William Dillard
14. MOTHER'S MAIDEN NAME: Nealie Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — *******
16. SOCIAL SECURITY NO.: 216-18-5259
17. INFORMANT: Helen Chase — Address: 22 Cornhill St Anna, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Chronic - Vascular Accident
DUE TO: Hypertensive Arterio Vascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): ~~Stroke~~
DUE TO
(c): Chronic Renal Disease
INTERVAL BETWEEN ONSET AND DEATH: 7 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA. DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(XXXXXXXX)~~ attended the deceased from 1-6-67, 19___, to Feb. 1, 1967, that (I) ~~(XX)~~ last saw the deceased alive on Feb. 1, 19 67, and that death occurred at 1:15 PM, from causes and on the date stated above.

22a. SIGNATURE: A. T. Allen M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2-2-67
22c. PHYSICIAN'S NAME (Type): A. T. Allen, M.D.
22d. ADDRESS: 62 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-4-67
23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
23d. LOCATION (City or Town) (County) (State): Annapolis A.A.Co Md

24. FUNERAL DIRECTOR: C.E. Hicks, III — ADDRESS: Annapolis, Md
25a. REC'D BY REGISTRAR DATE: FEB 6 1967
25b. REGISTRAR'S SIGNATURE: [signature]

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01644

CERTIFICATE OF DEATH

01641

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: A A Co — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): HERALD
   c. LENGTH OF STAY IN 1b: 10 years
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): RFD 2 Box 188 Ritchie Hwy

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md — b. COUNTY: A-A Co.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ARNOLD - Ritchie Hwy. 02.1
   d. STREET ADDRESS: RFD 2 Box 188
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MABEL — Middle H. — Last DUDLEY

4. DATE OF DEATH: Month 2 — Day 6 — Year 1967

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-25-82

9. AGE (In years last birthday): 84 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: (a) home

11. BIRTHPLACE (County & State, or foreign country): New York State

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRED C HINDS

14. MOTHER'S MAIDEN NAME: CARRIE SAUNDERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
    (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs George Tourner — Address: Above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Arteriosclerotic heart disease	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Coronary occlusion	
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from February, 1952, to Feb., 1967, that (I) (we) last saw the deceased alive on 1-5 1967, and that death occurred at 11:20 AM, from the causes and on the date stated above.

22a. SIGNATURE: E. Schnitzer M.D. — ATTENDING PHYS. [X] MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-8-67

22c. PHYSICIAN'S NAME (Type): EUGENE SCHNITZER M.D.

22d. ADDRESS: 3904 S. HANOVER ST. Balto. Md. 21225

23a. ~~BURIAL~~, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 2/8/67

23c. NAME OF CEMETERY OR CREMATORY: Fee Crematory

23d. LOCATION (City, town or county) (State): Washington D.C.

24. FUNERAL DIRECTOR — ADDRESS: Robert S. Edmonston, Severna Park, Md.

25a. REC'D BY REGISTRAR DATE: FEB 9 1967

25b. REGISTRAR'S SIGNATURE:

VR A15 (4)
20M 1/65

1 (M) 01645

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01642

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: North Carolina — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greensboro
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lunetta — Middle: (none) — Last: ERWIN

4. DATE OF DEATH: Month: February — Day: 6 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 23, 1885

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): N. Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Simpson Wheeler

14. MOTHER'S MAIDEN NAME: Charlotte Wheeler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Mary E. Wayman Hartsville S.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro Vascular accident — INTERVAL BETWEEN ONSET AND DEATH
260X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): arteriosclerotic Cerebro Vascular Disease
DUE TO (c): Diabetes mellitus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(his/her/last)~~ attended the deceased from 1-24-67, 19___, to Feb. 6, 1967, that (I) ~~(saw)~~ last saw the deceased alive on Feb. 6, 1967, and that death occurred at 9:55 PM, from causes and on the date stated above.

22a. SIGNATURE: A. T. Allen M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 2-7-67

22c. PHYSICIAN'S NAME (Type): A. T. Allen, M.D.

22d. ADDRESS: 62 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2-11-1967 — 23c. NAME OF CEMETERY OR CREMATORY: Dist Tidewater — 23d. LOCATION (City or Town) (County) (State): Laurel Md.

FUNERAL DIRECTOR: Edward L. Reed — ADDRESS: Laurel Md.

25a. REC'D BY REGISTRAR DATE: FEB 8 1967 — 25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01646

CERTIFICATE OF DEATH

01643

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XXXX- GLEN BURNIE
c. LENGTH OF STAY IN 1b: 35 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NORTH ARUNDEL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XXXX- GLEN BURNIE
d. STREET ADDRESS: 221 OAK LANE S.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First NORMAN — Middle LeRoy — Last ESTELLE

4 DATE OF DEATH: Month FEBRUARY — Day 20 — Year 1967

5 SEX: MALE

6 COLOR OR RACE: WHITE

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: AUGUST 23, 1903

9. AGE (In years last birthday): 63 YRS

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min ___

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DEPT. MANAGER

10b KIND OF BUSINESS OR INDUSTRY: RETAIL STORE

11. BIRTHPLACE (County & State, or foreign country): NEW JERSEY

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Robert Frank Estelle

14. MOTHER'S MAIDEN NAME: Lottie Reed

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk-1
(If yes give war or dates of service): Unk-1

16. SOCIAL SECURITY NO: 156-09-3222

17 INFORMANT — Address: Mrs. Janet A. Estelle (wife) Same as #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lft Ventricular Failure
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
4200

INTERVAL BETWEEN ONSET AND DEATH: 1-2 Yrs / Years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Renal Failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/16/67, 19___, to 2-20, 19 67 that (I) (we) last saw the deceased alive on 2-20 19 67, and that death occurred at ___M, from causes and on the date stated above.

22a SIGNATURE: Hilary T. O'Herlihy M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 2/20/67

22c. PHYSICIAN'S NAME (Type): Hilary T. O'Herlihy, M.D.

22d ADDRESS: 5 Central Avenue, S.W., Glen Burnie, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: Feb. 24, 1967

23c NAME OF CEMETERY OR CREMATORY: Balto. National Cemetery

23d LOCATION (City or Town) (County) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR — ADDRESS: Richard V. Singleton Glen Brunie, Md.

25a REC'D BY REGISTRAR DATE: FEB 23 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01647

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01644

1 PLACE OF DEATH
a. COUNTY: A.A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A - Anne Arundel Gen

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: MD
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Glenburnie
d. STREET ADDRESS: 3-C Laurel Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Donald — Middle: E — Last: Evans

4 DATE OF DEATH: Month: 2 — Day: 1 — Year: 1967

5 SEX: M

6 COLOR OR RACE: W

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 12-15-23

9 AGE (In years last birthday): 43 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Co. finish

10b KIND OF BUSINESS OR INDUSTRY: Construction

11 BIRTHPLACE (State or foreign country): South Dakota

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Harry Evans

14 MOTHER'S MAIDEN NAME: Lucy

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes give war or dates of service): WW II

16 SOCIAL SECURITY NO: 514 12 3737

17 INFORMANT: Shirley A Evans — Address: Glenburnie Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b):
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): E. Linhardt, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

22. DATE SIGNED: 2-1-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: Feb 6, 1967

23c NAME OF CEMETERY OR CREMATORY: Arlington National

23d LOCATION (City or Town) (County) (State): Arlington Virginia

24 FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.

25a RECD BY REGISTRAR: FEB 6 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01648

CERTIFICATE OF DEATH

01645

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN ib: 16 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Edgewater
d. STREET ADDRESS: Rt-1, Box-378C
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Laura — Middle: Eleanor — Last: FARRINGTON
4 DATE OF DEATH: Month: February — Day: 17 — Year: 19 67
5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: June 16, 1898
9 AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b KIND OF BUSINESS OR INDUSTRY: State of Md.
11 BIRTHPLACE (County & State or foreign country): Pittsburgh, Pennsylvania
12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: UNKNOWN
14 MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16 SOCIAL SECURITY NO.: 213-36-5674
17. INFORMANT: J.G. FARRINGTON — Address: Edgewater, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Thrombosis, left middle cerebral artery — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Arteriosclerotic Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Pyelonephritis with uremia
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (~~the physician~~) attended the deceased from Feb. 1, 19 67 to Feb. 16, 19 67, that (I) (we) last saw the deceased alive on Feb. 16 1967, and that death occurred at 1:30 AM M, from causes and on the date stated above.

22a SIGNATURE: Richard N. Peeler M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 2/17/67
22c. PHYSICIAN'S NAME (Type): Richard N. Peeler, M.D.
22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 2-20-67
23c NAME OF CEMETERY OR CREMATORY: Glen Haven
23d LOCATION (City or Town) (County) (State): Glen Burnie, Md

24. FUNERAL DIRECTOR: T.A. Hardesty, Annapolis, Md — ADDRESS
25a REC'D BY REGISTRAR DATE: FEB 21 1967
25b REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01649 Item 3 rlm 3/6/67 mn

CERTIFICATE OF DEATH

01646

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 23 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harwood
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Ella — Middle Mae (AKA Foster) — Last FORRESTER
4. DATE OF DEATH: Month February — Day 19 — Year 19 67

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED XX — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐
8. DATE OF BIRTH: May 10, 1891
9. AGE (In years at last birthday): 75 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: *******
11. BIRTHPLACE (County & State, or foreign country): A.A.Co Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Booze
14. MOTHER'S MAIDEN NAME: Eliza ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — *******
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Clarence Forrester, Beard Point Rd — Address: Davidsonville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Chronic Renal Disease — 22 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): Cardiac failure

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO XX

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year Hour of m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~his hospital~~) attended the deceased from Jan. 27, 19 67, to Feb. 19, 19 67, that (I) (~~he~~) last saw the deceased alive on Feb. 19 1967, and that death occurred at 6:05 AM, from causes and on the date stated above.

22a. SIGNATURE: A. T. Allen
M.D ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2-20-67
22c. PHYSICIAN'S NAME (Type): A. T. Allen, M.D.
22d. ADDRESS: 62 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-22-67
23c. NAME OF CEMETERY OR CREMATORY: Davidsonville
23d. LOCATION (City or Town) (County) (State): Davidsonville A.A.Co, Md

24. FUNERAL DIRECTOR — ADDRESS: C.F. Hicks, III Annapolis, Md
25a. REC'D BY REGISTRAR DATE FEB 24 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01650

CERTIFICATE OF DEATH

01647

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel general

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) ✓
a. STATE: Md.
b. COUNTY: Calvert
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Island Creek
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Alice — Middle: Cora — Last: Fowler

4. DATE OF DEATH: Month: 2 — Day: 24 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-7-72

9. AGE (In years last birthday): 94 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Columbus Buckmaster

14. MOTHER'S MAIDEN NAME: Cynthia Ann Buckmaster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 215-54-5072

17. INFORMANT: Daughter
Address: Island creek

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO (b): Overhydration renal atrophy — 14 days
DUE TO (c): Arteriosclerotic vascular disease with

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Intertrochanteric fracture, hip right severe

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Fell in her home

20c. TIME OF INJURY Hour & m. p.m. Month, Day, Year: 2-10 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): — (County): Calvert (State): Md

21. I certify that (I) (this hospital) attended the deceased from 2-11 19 67 to 2-24 19 67 that (I) (we) last saw the deceased alive on 2-24 19 67, and that death occurred at 1:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: Harold R Bohlmann M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-24-'67

22c. PHYSICIAN'S NAME (Type): Harold R Bohlmann

22d. ADDRESS: 96 Cathedral St Annapolis Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 27, 1967

23c. NAME OF CEMETERY OR CREMATORY: Christ Church Cemetery

23d. LOCATION (City or Town): Port Republic (County): Calvert (State): Md.

24 FUNERAL DIRECTOR: A.A. Mackness & Son
ADDRESS: Port Republic Md

25a. RECD BY REGISTRAR DATE: FEB 28 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01651 01648

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH a COUNTY: Anne Arundel	MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution resident before admission) a STATE: Maryland	b COUNTY:
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis	c. LENGTH OF STAY IN 1b: 4 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital		d STREET ADDRESS: 83 MARKET ST	e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print) First: ZGeorge	Middle:	Last: FOX	4 DATE OF DEATH Month: February	Day: 18	Year: 19 67		
5 SEX: Male	6. COLOR OR RACE: White	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: Dec. 4, 1876	9 AGE (In years last birthday): 90 yrs	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): EDUCATOR RET.	10b KIND OF BUSINESS OR INDUSTRY: PUBLIC SCHOOLS	11 BIRTHPLACE (County & State, or foreign country): BALTO. CO. Maryland	12 CITIZEN OF WHAT COUNTRY? U.S.				
13 FATHER'S NAME: GEORGE FOX		14 MOTHER'S MAIDEN NAME: ADALINE COE					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	(If yes give war or dates of service) —	16 SOCIAL SECURITY NO	17 INFORMANT: GEORGE D. FOX	Address: #2			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS
DUE TO
(b)
DUE TO
(c)
493X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CHRONIC CYSTITIS

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) ~~(he/she)~~ attended the deceased from _____, 19____, to Feb. 18, 1967, that (I) ~~(he/she)~~ last saw the deceased alive on Feb. 18 1967, and that death occurred at 11:30 AM, from causes and on the date stated above.

22a SIGNATURE: Edward S Beck M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b DATE SIGNED: 2/20/67

CERTIFIER'S NAME (Type): Edward S. Beck, M.D. — 22d ADDRESS: 73 Franklin St., Annapolis, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	2/20/1967	FORK METHODIST CEM	BALTIMORE Co MD.

24. FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
JOHN M. TAYLOR. SONS	ANNAPOLIS MD.	FEB 21 1967	J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01652

item 23b - Feb. 6, 1967

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01649

1 PLACE OF DEATH a. COUNTY: AACo. MARYLAND b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Glen Burnie. c LENGTH OF STAY IN 1b: 21 / / / / d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.o A-- North Arundel Hosp.	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE: MD b COUNTY: AACo c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Pasadena. d STREET ADDRESS: Box 40A - Rt #1 Bayside Dr. e RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print)	First: ~~Kenneth~~ ISABEL	Middle: L	Last: Fry	4 DATE OF DEATH	Month: 2	Day: 1	Year: 1967	
5 SEX: F	6. COLOR OR RACE: W	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH: 7-2-14	9 AGE (In years last birthday): 52 yrs	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant	10b KIND OF BUSINESS OR INDUSTRY: NSA (Gov't)	11 BIRTHPLACE (State or foreign country): Shippensburg, Pa.	12 CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Davis A. Shank		14 MOTHER'S MAIDEN NAME: Mary E. Group	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): None	16 SOCIAL SECURITY NO: 174-05-2800	17 INFORMANT: Address: Kenneth L. Fry (Husband) Same as # 2	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Carcinomatosis Generalized — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Lambert M.D.
EXAMINER'S NAME (Type): E. Lambert M.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 2-1-67

23a BURIAL, CREMATION REMOVAL (Specify): Burial	23b DATE THEREOF: Feb. 6 1967	23c NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cem.	23d LOCATION (City or Town): Fort Meyer, Va.	(County) (State)
24 FUNERAL DIRECTOR: Eugene B. Fleming	ADDRESS: Singleton Funeral Home Glen Burnie, Md.	25a RECD BY REGISTRAR DATE: FEB 3 1967	25b REGISTRAR'S SIGNATURE: J. Charles Judge	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01653

CERTIFICATE OF DEATH

Reg. Dist. No. 01650

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL—CAPE ST. CLAIRE
c. LENGTH OF STAY IN 1b: 18 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Box 96 R.F.D#4 — CAPE ST. CLAIRE

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Md.
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAPE ST. CLAIRE
d STREET ADDRESS: Box 96 R.F.D. #4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Clara Middle L Last GASIOR

4. DATE OF DEATH: Month 2 Day 20 Year 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-10-98

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11 BIRTHPLACE (State or foreign country): BALTIMORE, Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MICHAEL BARYLSKI

14. MOTHER'S MAIDEN NAME: MARY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 217-46-4063

17. INFORMANT — Address: ALBERT F. GASIOR — Box 96 R.F.D. #4 CAPE ST. CLAIRE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Vascular accident with terminal	5 days
DUE TO	Bilateral Pneumonia	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Hypertension —	4 years
DUE TO (c)	Diabetes late apparition	4 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from February, 1963, to February 20, 1967, that I last saw the deceased alive on February 20, 1967, and that death occurred at 11:50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Bertrand C.R. Gau M.D. ADDRESS (Street, city or town, state): Box 177. Rt 4 Annapolis Md DATE SIGNED: 2.21.67

PHYSICIAN'S NAME (Type): Bertrand C.R. GAU

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b DATE THEREOF: 2/23/67

22c. NAME OF CEMETERY OR CREMATORY: HOLY ROSARY CEMETERY

22d LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: George R Weber — ADDRESS: 703 SOUTH ANN ST

24a. REC'D BY REGISTRAR DATE

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01654 — 01651

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 193 Woods Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Dorothy — Middle Holden — Last GEORGE
4. DATE OF DEATH: Month February — Day 14 — Year 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 26, 1922
9. AGE (In years last birthday): 44 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: A A Co
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Harry Lee Holden
14. MOTHER'S MAIDEN NAME: Josephine Coursey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 215-14-3599
17. INFORMANT: A.E George — Address: 193 Woods Dr

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 mins.
DUE TO (b): Coronary artery sclerosis — 4 yr.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatic heart disease, c mitral insufficiency.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~Coroner~~) attended the deceased from July, 19 55, to Feb., 1962, that (I) (~~last~~) saw the deceased alive on Dec. 26 1966, and that death occurred at 2:35 M, from causes and on the date stated above

22a. SIGNATURE: John L Hedeman M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2/15/67
22c. PHYSICIAN'S NAME (Type): John L. Hedeman
22d. ADDRESS: 1407 Forest Drive, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-18-67
23c. NAME OF CEMETERY OR CREMATORY: Sudlersville
23d. LOCATION (City or Town) (County) (State): Sudlersville, Md AA Co

24. FUNERAL DIRECTOR: T A Hardesty — ADDRESS: Annapolis, Md

25a. REC'D BY REGISTRAR DATE: FEB 21 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01655 — 01652

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
d. STREET ADDRESS: 3525 South River Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Babette — Middle: — Last: GERHAB
4. DATE OF DEATH: Month: February — Day: 3, — Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: February 19, 1891
9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: BRUNO MILLER
14. MOTHER'S MAIDEN NAME: MARGARET HEINEL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO:
17. INFORMANT: LOCH RAVEN BEACH — Address: MRS. SAMUEL CRAWFORD A.A.Co. MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Renal Shutdown — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: indefinite
DUE TO
(c):
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. 731X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/26, 1966, to 2/3, 1967, that (I) (we) last saw the deceased alive on February 3 1967, and that death occurred at 10:35 P.M. from causes and on the date stated above.

22a. SIGNATURE: Richard I. Hochman M.D — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2/4/67
22c. PHYSICIAN'S NAME (Type): Richard I. Hochman M.D
22d. ADDRESS: 59 Franklin St. Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2-8-1967
23c. NAME OF CEMETERY OR CREMATORY: HILLSIDE CEM.
23d. LOCATION (City or Town) (County) (State): PHILA. PA.

24. FUNERAL DIRECTOR — ADDRESS: JOHN M. TAYLOR SONS ANNAPOLIS MD
25a. REC'D BY REGISTRAR DATE: FEB 8 1967
25b. REGISTRAR'S SIGNATURE: Frances Judge

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01656 01653

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Baltimore
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6043 Ritchie Hgwy.

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Baltimore
d. STREET ADDRESS: 6043 Ritchie Hgwy.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First FRANKLIN — Middle D. — Last GREEN

4. DATE OF DEATH: Month February — Day 2 — Year 1967

5 SEX: Male

6 COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: July 12, 1888

9 AGE (In years last birthday): 78 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor

10b KIND OF BUSINESS OR INDUSTRY: Railroad

11 BIRTHPLACE (County & State, or foreign country): Baltimore, Md.

12 CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Joshua Green

14. MOTHER'S MAIDEN NAME: Mary Ellen DeBow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): W W I

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Mrs. Rita Green (same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Metastatic Carcinoma Liver Lung ? — INTERVAL BETWEEN ONSET AND DEATH: Comparatively
DUE TO
(b): Carcinoma Stomach — 8 yrs
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 1, 19 57, to Feb 2, 19 67, that (I) (we) last saw the deceased alive on Feb 1 19 62, and that death occurred at 12:36 AM, from causes and on the date stated above.

22a. SIGNATURE: Benjamin Berdann — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Feb. 2, 1967

22c. PHYSICIAN'S NAME (Type): Dr. Benjamin Berdann

22d. ADDRESS: 5010A Gov. Ritchie Hgwy., Baltimore

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-4-1967

23c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery

23d. LOCATION (City or Town) (County) (State): Ritchie Hgwy & A.A.Co., Md.

24 FUNERAL DIRECTOR — ADDRESS: George J. Gonce-4001 Ritchie Hgwy., Baltimore

25a. REC'D BY REGISTRAR — DATE: FEB 6 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01657 — 01654

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — c LENGTH OF STAY IN 1b: D.O.A.	c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): RURAL - Annapolis
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): (Dead on arrival) AnneArudel General Hospital	d. STREET ADDRESS: 103 HUSE DR — e IS RESIDENCE ON A FARM? YES ☐ NO ☒
3 NAME OF DECEASED (Type or print): First Grover Middle STEVENSON Last GRIMES, Sr.	4 DATE OF DEATH: Month Feb. Day 21 Year 1967
5 SEX: M — 6 COLOR OR RACE: W — 7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8 DATE OF BIRTH: 7-20-1892 — 9 AGE (In years last birthday): 74 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONSTRUCTION — 10b KIND OF BUSINESS OR INDUSTRY: Building — 11 BIRTHPLACE (County & State, or foreign country): A.A. Co., Md. — 12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: JOHN GRIMES — 14 MOTHER'S MAIDEN NAME: HARDY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — — 16. SOCIAL SECURITY NO — 17 INFORMANT Address: Elizabeth D. Grimes #2	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary occlusion — 1 yr
DUE TO
(b): Coronary artery disease — 10 yrs
DUE TO
(c): Arteriosclerosis, cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Jan, 19 51, to Feb 21, 1967, that (I) (~~he~~) last saw the deceased alive on Feb 19 1967, and that death occurred at 7:10 PM from causes and on the date stated above.

22a. SIGNATURE: S Borssuck M D	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: 2/22/67	
22c. PHYSICIAN'S NAME (Type): Samuel Borssuck, M.D.	22d ADDRESS: Amos Garrett Blvd., Annapolis, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE THEREOF: 2-24-67	23c. NAME OF CEMETERY OR CREMATORY: HENDERSON METH. Cem.	23d LOCATION (City or Town): CALLAO (County): (State): Va.
24 FUNERAL DIRECTOR: John M. Taylor & Sons	ADDRESS: Annapolis, Md.	25a REC'D BY REGISTRAR DATE: FEB 28 1967	25b REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01658 — 01655

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanover
c. LENGTH OF STAY IN 1b: Life Time
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route #2, Box 18

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanover
d. STREET ADDRESS: Route #2, Box 18
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Essie — Middle: Viola — Last: Hamilton

4. DATE OF DEATH: Month: February — Day: 20 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: August 15, 1896

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Private Family

11. BIRTHPLACE (County & State, or foreign country): Severn, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Samuel Harris

14. MOTHER'S MAIDEN NAME: Mariah Gamble

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 215-16-2382

17. INFORMANT: Mr. Clarence Hamilton — Address: Hanover, Md — Route 2 Box 18

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemmorrhage

DUE TO (b): R.T. Hemiplegia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Hypertension

INTERVAL BETWEEN ONSET AND DEATH: 5 mos — 1 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 20, 19 67 to Feb. 20, 19 67, that (I) (we) last saw the deceased alive on Feb. 1, 19 67, and that death occurred at 3:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Frank E. Shipley M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/22/67

22c. PHYSICIAN'S NAME (Type): Frank E. Shipley, M.D.

22d. ADDRESS: Severn, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb 23, 1967

23c. NAME OF CEMETERY OR CREMATORY: Baltimore, National Cem.

23d. LOCATION (City, town or county) (State): Baltimore, Md

24 FUNERAL DIRECTOR'S SIGNATURE: Herbert E. Nutter — ADDRESS: 3035 W. North Ave

25a. REC'D BY REGISTRAR — DATE: FEB 24 1967

25b. REGISTRAR'S SIGNATURE: Wilmer A. Yeager

VR A1S (4) 20M S-63

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01659

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01656

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY [illegible] MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) [illegible]

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE [illegible] b. COUNTY [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS 12 Bunche St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Abraham Middle: [illegible] Last: Hatton

4. DATE OF DEATH Month: 2 Day: 2 Year: 1967

5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-26-1906
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sam Hatton
14. MOTHER'S MAIDEN NAME: Matilda [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Elizabeth Hatton Address: 12 Bunche St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerosis generalized — INTERVAL BETWEEN ONSET AND DEATH: Years
I500
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE [signature] M.D.
EXAMINER'S NAME (Type) E. L. Inbrandt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED 2/2/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF 2-5-1967
23c. NAME OF CEMETERY OR CREMATORY: Bowman's Hill
23d. LOCATION (City, town or county) (State): Annapolis Md.

24. FUNERAL DIRECTOR: William Russell
ADDRESS: Annapolis Md.

25a. REC'D BY REGISTRAR DATE: FEB 6 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME
35DD 4 64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01660

CERTIFICATE OF DEATH

01657

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 443 Crain Highway N/E
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: L. — Last: Hein Sr.

4. DATE OF DEATH: Month: February — Day: 3 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 31, 1899

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self-Employed

10b. KIND OF BUSINESS OR INDUSTRY: Fuel Oil

11. BIRTHPLACE (County & State, or foreign country): Fairfield, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Hein

14. MOTHER'S MAIDEN NAME: Anna Grothey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): ////////

16. SOCIAL SECURITY NO.: 216/05/8657

17. INFORMANT: Mrs Helen R. Hein — Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Advanced Coronary Arteriosclerosis
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o'm p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 1/63, 19__, to 2/2, 1967, that (I) ~~(we)~~ last saw the deceased alive on 2/2, 1967, and that death occurred at 4:45 A.M., from causes and on the date stated above.

22a. SIGNATURE: Wayne B. Yates M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/3/67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 6, 1967

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Brooklyn RFD Md.

24. FUNERAL DIRECTOR: R.V. SINGLETON — ADDRESS: GLEN BURNIE, MD.

25a. REC'D BY REGISTRAR — DATE: FEB 10 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01661 01658

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 7/61

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft. Geo. Meade,
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kimbrough Army Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Res dence before admiss on)
e. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): JESSUP
d. STREET ADDRESS: Box 419 - A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LESTER Middle DEWEY Last HIGGS

4. DATE OF DEATH: Month February Day 1 Year 1967

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 23 April 1899

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter (Ret)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Stanley, Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas J. Higgs

14. MOTHER'S MAIDEN NAME: Barbara E. Painter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes Oct 1919-Oct 1922

16. SOCIAL SECURITY NO.: 212-09-1508

17. INFORMANT: Mrs. Lottie L Higgs, Name as #2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion
DUE TO (b): Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ___ a.m. p.m. ■ Month, Day, Year

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/9/67, to 2/1/67, that (I) (we) last saw the deceased alive on 1/23/67 19 ..., and that death occured at ... M, from the causes and on the date stated above.

22a. SIGNATURE: Joseph E. Smith, Jr. M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Joseph E. Smith, Jr. M.D.

22d. ADDRESS: Burtonsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Feb. 4, 1967

23c. NAME OF CEMETERY OR CREMATORY: Good Shepherd Cemetery, RFD, Ellicott City, Maryland

23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Harold S. Wade, 550 Nash. Blvd. Laurel, Maryland

25a. REC'D BY REGISTRAR DATE: FEB 8 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 6,9 Film G 56 2/24/67 mh

01662

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01659

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Anco- — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Glen Burnie
   c. LENGTH OF STAY IN 1b
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bon-Secours Anne Arundel Hosp
2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: MD — b. COUNTY: Anco.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn 26, md
   d. STREET ADDRESS: 1005 Park Place
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐
3. NAME OF DECEASED (Type or print): First: Harry — Middle: W. — Last: Hobson
4. DATE OF DEATH: Month: 2 — Day: 15 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2/8/1911
9. AGE (In years last birthday): 55 yrs 5/4
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A
13. FATHER'S NAME: William Hobson
14. MOTHER'S MAIDEN NAME: Maude Cuttermuth
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 214-05-3167
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
    PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Sudden
    Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (b): ATH — DUE TO (c):
    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour o.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E Linhardt M.D.
EXAMINER'S NAME (Type): E Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 2/17/67

23a. BURIAL, CREMATION OR REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/20/67
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven
23d. LOCATION (City or Town) (County) (State): Glen Burnie AA Md.

24. FUNERAL DIRECTOR: McCully — ADDRESS: 237 Patapsco Ave.

25a. REC'D BY REGISTRAR — DATE: FEB 17 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01663

CERTIFICATE OF DEATH

01660

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 2-2nd Ave
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2-2nd Ave Balto 21225

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md — b. COUNTY: A A Co
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 2-2nd Ave
   d. STREET ADDRESS: Baltimore
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Agnes — Middle: M — Last: Hooper

4. DATE OF DEATH: Month: Feb — Day: 17 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 13,1906

9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George T Hooper

14. MOTHER'S MAIDEN NAME: Louise Schneider

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family — Address: Same

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of (L) Breast
DUE TO (b): Metastasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1 Feb 67, 19..... to 17 Feb, 19 67 that (I) (we) last saw the deceased alive on 17 Feb 67 19....., and that death occurred at 4:40 M, from the causes and on the date stated above.

22a. SIGNATURE: J. R. Sossnowski M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/20/67

22c. PHYSICIAN'S NAME (Type): J. R. Sossnowski

22d. ADDRESS: 4016 Ritchie Hwy Balto 21 Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/21/67

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem

23d. LOCATION (City, town or county): A A Co. (State): Md

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: McCully F H 237 Patapsco Ave 21225

25a. REC'D BY REGISTRAR DATE: FEB 21 1967

25b. REGISTRAR'S SIGNATURE:

VR A15 (2)
20M 5-63

1

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01664 01664

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO. G. MEADE
c. LENGTH OF STAY IN 1b: 2 HOURS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ODENTON
d. STREET ADDRESS: 570 RITA DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WASHINGTON; Middle I; Last HOUGHTON

4. DATE OF DEATH: Month FEBRUARY; Day 7; Year 1967

5. SEX: MALE

6. COLOR OR RACE: CAU

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: MARCH 15, 1915

9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SOLDIER

10b. KIND OF BUSINESS OR INDUSTRY: U.S. ARMY

11. BIRTHPLACE (County & State, or foreign country): MONTGOMERY, MD.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ERNEST HOUGHTON

14. MOTHER'S MAIDEN NAME: Beulah Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): YES Jun 43-Oct 63

16. SOCIAL SECURITY NO.: 579-01-2185

17. INFORMANT: DOROTHY L. HOUGHTON (W) Address: 570 Rita Drive ODENTON, MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Laennec;s Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Peritonitis — 2 Hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(X)~~ attended the deceased from Feb 7, 1967, to Feb 7, 1967, that (I) (~~X~~) last saw the deceased alive on 7 Feb 67, 1967, and that death occurred at 1140 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Jorge Ramirez M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 7 February 1967

22c. PHYSICIAN'S NAME: JORGE J. RAMIREZ, CPT, MC

22d. ADDRESS: KIMBROUGH AH FORT GEORGE G. MEADE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 10, 1967

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.

23d. LOCATION (City, town or county) (State): Ft. Myer, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Bentley A. Hopping

ADDRESS: Hopping Funeral Home 172 West St., Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: FEB 10 1967

25b. REGISTRAR'S SIGNATURE: Wesley Yeager

7 1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01663 **CERTIFICATE OF DEATH** 01662

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Nme Box 159, Ft. Smallwood Rd.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena
d. STREET ADDRESS Ft Smallwood Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Richard Middle: Elmer Last: Houser
4. DATE OF DEATH Month: February Day: 20 Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 8, 1911
9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Crane Operator
10b. KIND OF BUSINESS OR INDUSTRY: Scrap Co.
11. BIRTHPLACE (County & State, or foreign country): Frederick, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Harry Houser
14. MOTHER'S MAIDEN NAME: ----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW 2
16. SOCIAL SECURITY NO.: 236-12-9085
17. INFORMANT: Elizabeth Houser Address: Pasadena, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial infarction	3 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	essential hypertension	2 years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from June 1, 1950 to Feb. 20, 1967, that (I) (~~we~~) last saw the deceased alive on Feb 13, 1967, and that death occurred at 6:4 M, from the causes and on the date stated above.

22a. SIGNATURE: R. M. McLaughlin M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/20/67
22c. PHYSICIAN'S NAME (Type): R. M. McLaughlin
22d. ADDRESS: 3708 Mountain Rd. Pasadena, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-22-1967
23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR ADDRESS: George J. Gonce-4001 Ritchie Hgwy., Baltimore
25a. REC'D BY REGISTRAR DATE: FEB 24 1967
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01666 01663

PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 703 Severn Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas Middle: Anthony Last: HUGHES
4. DATE OF DEATH: Month: February Day: 11 Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 9, 1914
9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Publications Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Government
11. BIRTHPLACE (County & State, or foreign country): Eastport Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Joseph Hughes
14. MOTHER'S MAIDEN NAME: Caroline Winchester
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WWII
16. SOCIAL SECURITY NO: 214-05-2580
17. INFORMANT: Mrs J.F. Gomolak Address: Annapolis, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
INTERVAL BETWEEN ONSET AND DEATH: 2 4 Hours

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 2/11, 1967, to Feb. 11, 1967 that (I) (~~We~~) last saw the deceased alive on Feb. 11, 1967, and that death occurred at 6:45 PM from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/13/67
22c. PHYSICIAN'S NAME (Type): Richard I. Hochman M.D.
22d. ADDRESS: 59 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-14, 1967
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's
23d. LOCATION (City or Town) (County) (State): Annapolis, Md AA Co.
24. FUNERAL DIRECTOR: T.A. Hardesty ADDRESS: 12 Ridgely Ave, Annapolis, Md
25a. RECD BY REGISTRAR DATE: FEB 21 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01667 Item 9 Film G506 2/21/67 01664

1. PLACE OF DEATH
a. COUNTY: Anne Arundel County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie,
d. STREET ADDRESS: 1109 Armistead St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carrie; Middle: B.; Last: Hull

4. DATE OF DEATH: Month: Feb.; Day: 16; Year: 1967

5. SEX: Female

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-20-84

9. AGE (In years last birthday): 82 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL KEEFER

14. MOTHER'S MAIDEN NAME: MARGARET ZIES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular Thrombosis
DUE TO (b): Generalized arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 2-3 yrs / years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-15-, 1967, to 2-16-, 1967, that (I) (we) last saw the deceased alive on 2-16-1967, and that death occurred at 5 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Harry J. Berkley — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-16-67

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2.18.67

23c. NAME OF CEMETERY OR CREMATORY: REHOBETH METHODIST

23d. LOCATION (City, town or county) (State): FULTON COUNTY PENNA.

24. FUNERAL DIRECTOR — ADDRESS: Howard J. Grove Hancock Md.

25a. REC'D BY REGISTRAR DATE: FEB 23 1967

25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01668

CERTIFICATE OF DEATH

01665

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: A A C — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 3 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Anne Arundel Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before Admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: Box 262, Route 4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Patrick — Middle THOMAS PATRICK — Last Hummer
4. DATE OF DEATH: Month 2 — Day 5 — Year 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-16-66
9. AGE (In years last birthday): — yrs
IF UNDER 1 YEAR: Months 2 — Days 20
IF UNDER 24 HRS: Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Silver Spring, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Paul Wesley Hummer
14. MOTHER'S MAIDEN NAME: Donna Marie Pilgrim

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give War or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Paul W. Hummer — Address: (same as # 2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-respiratory failure
DUE TO (b): Etiology undetermined
DUE TO (c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1730
INTERVAL BETWEEN ONSET AND DEATH: 8 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 5, 1967, to Feb 5, 1967, that (I) (we) last saw the deceased alive on Feb 5 1967, and that death occurred at 6:10 M, from causes and on the date stated above.

22a. SIGNATURE: Frank M. Kopack M.D. — M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/5/1967
22c. PHYSICIAN'S NAME (Type): FRANK M. KOPACK
22d. ADDRESS: Annapolis Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 7, 1967
23c. NAME OF CEMETERY OR CREMATORY: Date of Heaven
23d. LOCATION (City or Town) (County) (State): Montgomery Co Md

24. FUNERAL DIRECTOR: J. Arthur Watkins — ADDRESS: 254 Carroll St NW Washington DC
25a. REC'D BY REGISTRAR DATE: FEB 7 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01663

CERTIFICATE OF DEATH

01666

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenland Beach
c. LENGTH OF STAY IN 1b: 35 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 8052 Ft. Smallwood Road

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenland Beach
d. STREET ADDRESS: 8052 Ft. Smallwood Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle MATTHEW — Last JEFFERSON

4. DATE OF DEATH: Month Feb. — Day 2, — Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 17, 1905

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Parts dealer

10b. KIND OF BUSINESS OR INDUSTRY: Automobile

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Albert Jefferson

14. MOTHER'S MAIDEN NAME: Eva Shultz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 215-32-5457

17. INFORMANT: Mrs. Thelma Jefferson — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
60 X
DUE TO (b): diabetes mellitus — 10 years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic osteomyelitis 30 years

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from June 1, 1950, to February 2, 1967, that (I) (we) last saw the deceased alive on Feb. 2 1967, and that death occurred at 9 P.M., from the causes and on the date stated above.

22a. SIGNATURE: R. M. McLaughlin — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/2/67

22c. PHYSICIAN'S NAME (Type): R. M. McLaughlin

22d. ADDRESS: 3708 Monastir Rd. Baltimore, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 6, 1967

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Park Cem.

23d. LOCATION (City, town or county) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR — ADDRESS: George J. Gonce — 4001 Ritchie Hwy. (21225)

25a. REC'D BY REGISTRAR DATE: FEB 1967

25b. REGISTRAR'S SIGNATURE: Harris Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01630 — 01667

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Annapolis
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Rural, Pasadena 21122
d. STREET ADDRESS: 201 Mission St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Benton — Middle: (nmi) — Last: Johnson
4. DATE OF DEATH: Month: February — Day: 25 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/15/92
9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self-employed (ret.)
10b. KIND OF BUSINESS OR INDUSTRY: Service Station
11. BIRTHPLACE (County & State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Johnson
14. MOTHER'S MAIDEN NAME: Hattie Linthicum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None
16. SOCIAL SECURITY NO: 217-34-6855
17. INFORMANT: Mrs. Gladys D. Johnson (wife) — Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Congestive HeartFailure — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO
(b) Hypertensive Arteriosclerotic Heart Disease
DUE TO
(c)
If any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov. 1956 to Feb. 1967, that (I) (we) last saw the deceased alive on Feb 24 1967, and that death occurred at 4:30 AM from causes and on the date stated above.

22a. SIGNATURE: Francis J. Codd M.D — ATTENDING PHYS XXXX ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2-27-67
22c. PHYSICIAN'S NAME (Type): Francis J. Codd, MD
22d. ADDRESS: Ritchie Highway, Severna Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 28, 1967
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Park
23d. LOCATION (City or Town) (County) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR: Richard V. Singleton — ADDRESS: Glen Burnie, Maryland
25a. RECD BY REGISTRAR DATE: FEB 28 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01671

CERTIFICATE OF DEATH

01668

1 **PLACE OF DEATH**
a COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a STATE: Maryland — b COUNTY: Anne Arundel
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d STREET ADDRESS: 39 Calvert St.,
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 **NAME OF DECEASED** (Type or print): First: Carla — Middle: Ann — Last: JOHNSON

4 **DATE OF DEATH**: Month: February — Day: 12 — Year: 19 67

5 SEX: Female

6 COLOR OR RACE: Negro

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 13, 1966

9 AGE (In years last birthday): yrs

IF UNDER 1 YEAR: Months: 3 — Days: 30
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Anne Arundel, Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Vernon Johnson

14. MOTHER'S MAIDEN NAME: Barbara Wallace

15 WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16 SOCIAL SECURITY NO.

17. **INFORMANT** Address: Barbara Wallace 39 Calvert St

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Bilateral bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 **I certify** that (I) ~~(the hospital)~~ attended the deceased from Feb. 12, 1967, to Feb. 12, 19 67 that (I) ~~(he)~~ last saw the deceased alive on Feb. 12 19 67, and that death occurred at 12:05 PM, from causes and on the date stated above.

22a SIGNATURE: Charles B. Hargrove M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 2/13/67

22c. PHYSICIAN'S NAME (Type): Charles B. Hargrove, M.D.

22d. ADDRESS: Hahn ProfBldg., Severna Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 2-16-1967

23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

23d LOCATION (City or Town) (County) (State): Annapolis Md.

24 FUNERAL DIRECTOR: William Reese — ADDRESS: Annapolis Md.

25a RECD BY REGISTRAR DATE: FEB 14 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

B

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01672

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01669

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie-rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel General

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Baltimore 30-
d. STREET ADDRESS: 2200½ Eutaw Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Rosetta — Middle: K. — Last: Johnson
4. DATE OF DEATH: Month: 2 — Day: 18 — Year: 1967

5 SEX: female
6 COLOR OR RACE: colored
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct 20, 1939
9 AGE (In years last birthday): 27 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNK.
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Richmond, Virginia
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNK.
14. MOTHER'S MAIDEN NAME: Carrie Eaddy

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16 SOCIAL SECURITY NO:
17 INFORMANT: Mr. Jack H. Johnson — Address: 3832 Reisterstown

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute alcoholic intoxication, possibly
DUE TO: associated with exposure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspect on ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D. M.D
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 2-24-67
23c NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park
23d LOCATION (City or Town) (County) (State): Arbutus — Md.

24 FUNERAL DIRECTOR: Morton Dyett F.H. — ADDRESS: 1701 Laurens St.
25a. RECD BY REGISTRAR — DATE FEB 23 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01673 — 01670

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** — a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 9 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Plaza Manor 7355 Furnace Brch Rd

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1612 Milton Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: William — Middle: E. — Last: Johnson
4. DATE OF DEATH: Month: 2 — Day: 23 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 5-25-1894
9. AGE (In years last birthday): 72
IF UNDER 1 YEAR — Months: — Days: —
IF UNDER 24 HRS. — Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10b. KIND OF BUSINESS OR INDUSTRY: Hospital
11. BIRTHPLACE (County & State, or foreign country): Belair, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Roff Johnson
14. MOTHER'S MAIDEN NAME: Catherine Stump

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): W.W. I
16. SOCIAL SECURITY NO.: 215-28-8649A
17. INFORMANT: Lena Wallace — Address: 1120 Abbott Ct.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO (b): Hypertensive Cardio Vascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Decompensation
INTERVAL BETWEEN ONSET AND DEATH: Several Hours
Duration Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED — While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 20, 1966 to Feb 23, 1967 that (I) (we) last saw the deceased alive on Feb 18, 1967, and that death occurred at .. M, from the causes and on the date stated above.

22a. SIGNATURE: R. Chard H. Hunt M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): R. Chard H. Hunt
22d. ADDRESS: 100 Church Lane Glen Burnie Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-27-67
23c. NAME OF CEMETERY OR CREMATORY: National Cemetery
23d. LOCATION (City, town or county) (State): Baltimore, Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Randolph J. Collick 2421 E. Oliver St.

25a. REC'D BY REGISTRAR DATE: FEB 28 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A1S (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01674

CERTIFICATE OF DEATH

01671

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): (Dead on Arrival) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 131 West St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eleanor — Middle: Davis — Last: JONES
4. DATE OF DEATH: Month: February — Day: 15 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 23, 1913
9. AGE (In years last birthday): 53 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: *********
11. BIRTHPLACE (County & State, or foreign country): Annapolis Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: William Davis
14. MOTHER'S MAIDEN NAME: Babara Taylor
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): *********
16. SOCIAL SECURITY NO: 212-16-4923
17. INFORMANT: Clinton Dorsey — Address: 112 South Villa Ave Anna. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
DUE TO
(b): Hypertension
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~discharged~~) attended the deceased from 7-12-66, 19___, to 2-15-, 1967, that (I) (~~saw~~) last saw the deceased alive on 1-3-, 1967, and that death occurred at 10:20 AM, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2-16-67
22c. PHYSICIAN'S NAME (Type): F.M. STIPLEY
22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 18-67
23c. NAME OF CEMETERY OR CREMATORY: Pine Lawn Memorial
23d. LOCATION (City or Town) (County) (State): Best gate Rd Annapolis Md
24. FUNERAL DIRECTOR — ADDRESS: C.E. Hicks, 111 Annapolis, Md
25a. RECD BY REGISTRAR DATE: FEB 20 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01675 — 01672

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 5-63

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mayo
c. LENGTH OF STAY IN 1b: MARYLAND 35 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Mayo

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mayo
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hugh Middle: Evans Last: Jones, Sr.

4. DATE OF DEATH: Month: 2 Day: 19 Year: 1967

5. SEX: M. 6. COLOR OR RACE: W. 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 18, 1890

9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boat Builder

10b. KIND OF BUSINESS OR INDUSTRY: Civil Service

11. BIRTHPLACE (County & State, or foreign country): Dalzell, South Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ROBERT LEE JONES

14. MOTHER'S MAIDEN NAME: FRANCES ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes

16. SOCIAL SECURITY NO.: 220-03-8451

17. INFORMANT: Hugh E. Jones, Jr. Address: 23 Farragut Rd, Bay Ridge, Annapolis, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 5 hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic cardio-Vascular disease — 2 years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 4, 1967 to Feb. 19, 1967, that (I) (we) last saw the deceased alive on Feb. 19 1967, and that death occurred at 7.45 P.M. from the causes and on the date stated above.

22a SIGNATURE: Sylvia M. Link M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/20/67
22c. PHYSICIAN'S NAME (Type): Sylvia M. Link
22d. ADDRESS: Rt 1 Box 244 Edgewater, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-22-67
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest
23d. LOCATION (City, town or county): Annapolis (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR: DATE FEB 21 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

1

01676

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01673

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN this: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Edgewater
d. STREET ADDRESS: Old muddy creek road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: — Last: LAYMON
4. DATE OF DEATH: Month: February — Day: 5 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 5, 1906
9. AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): West Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: [illegible]
14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: [illegible] Address: Baltimore Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): Aspiration
DUE TO (c): Cerebrovascular Accident — 13 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~the physician~~) attended the deceased from Jan. 23, 1967, to Feb. 5, 1967, that (I) (~~he~~) last saw the deceased alive on Feb. 5, 1967, and that death occurred at 5:15 AM M. from causes and on the date stated above

22a. SIGNATURE: R. Biern — M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2/6/67
22c. PHYSICIAN'S NAME (Type): Robert O. Biern, M.D.
22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-8-1967
23c. NAME OF CEMETERY OR CREMATORY: Ghens Memorial
23d. LOCATION (City or Town) (County) (State): Millersville Md.

24. FUNERAL DIRECTOR: William Reese — ADDRESS: Annapolis Md.
25a. RECD BY REGISTRAR DATE: FEB 8 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 film 0013 2/2/67 EM

01677

CERTIFICATE OF DEATH

01674

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 7mos. 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1040 E. Lombard Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) #32736 — First: John — Middle: N. — Last: Leebrick

4. DATE OF DEATH — Month: 2 — Day: 17 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ sep. DIVORCED ☐
8. DATE OF BIRTH: 9/19/1897
9. AGE (In years last birthday): 68 69 yrs.
IF UNDER 1 YEAR — Months / Days
IF UNDER 24 HRS — Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Leebrick
14. MOTHER'S MAIDEN NAME: Ida Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: 577-09-4525
17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome sec. to Alcoholism, Inanition

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 7/21/66, 19__, to 2/17/, 1967, that (I) (we) last saw the deceased alive on 2/17 1967, and that death occurred at 12:39 M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐ A.
22b. DATE SIGNED: 2/17/67
22c. PHYSICIAN'S NAME (Type): L. Benedict, M.D.
22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/17/67
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City or Town) (County) (State): Lynchburg, Va.

24. FUNERAL DIRECTOR: Ellrich Funeral Hm. Balto. Md. — ADDRESS

25a. RECD BY REGISTRAR DATE: FEB 27 1967
25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01678 — Item #23b,c & d Fill. #V38-2-2/1/67 pc — 01675

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Brooklyn
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 314 W. 14th. Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn
d. STREET ADDRESS: 314 W. 14th. Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

02-1

3. NAME OF DECEASED (Type or print): First: Mamie — Middle: — Last: Leiman

4. DATE OF DEATH: Month: Feb. — Day: 12, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 2, 1888

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ho usewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (County & State, or foreign country): Balto Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Frederick Jacob

14. MOTHER'S MAIDEN NAME: Louisa Bartel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Ruth Norris — Address: 314 W. 14th. Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction with — INTERVAL BETWEEN ONSET AND DEATH: 30 days.

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): extension
DUE TO (c): Coronary artery disease with Left Bundle Br. Block

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 12/29, 1966, to 2/14, 1967, that (I) ~~(we)~~ last saw the deceased alive on 2/14 1967, and that death occurred at 6 a.m./p.m., from the causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Feb 13, 1967

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/16/67

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

23d. LOCATION (City, town or county) (State): A.A. Co. Md.

24. FUNERAL DIRECTOR: McCully Funeral Home — ADDRESS: 237 Patapsco Ave.

25a. REC'D BY REGISTRAR DATE: FEB 15 1967

25b. REGISTRAR'S SIGNATURE: [signature] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01679

CERTIFICATE OF DEATH

01676

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): City Baltimore 29
d. STREET ADDRESS: 653 Brisbane Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Margaret; Middle: Clara; Last: LOESCHKE
4. DATE OF DEATH: Month: February; Day: 4; Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: January 13, 1891
9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Debes
14. MOTHER'S MAIDEN NAME: Mary W. Hoenig

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 216-46-1783
17. INFORMANT: Mr. Paul H. Loeschke, Jr. Address: 653 Brisbane Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Congestive heart failure, acute — INTERVAL BETWEEN ONSET AND DEATH: 3 Hours
4201
DUE TO (b): Myocardial infarction, anteroseptal — 24 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arteriosclerosis, general and coronary — several years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from January 12, 19 67, to February 4, 19 67, that (I) (we) last saw the deceased alive on February 4, 19 67, and that death occurred at 6:20 A.M. from causes and on the date stated above

22a. SIGNATURE: Charles W. Kinzer M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: February 5, 1967
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.
22d. ADDRESS: South River Medical Building Edgewater, Maryland 21037

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2-7-1967
23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
23d. LOCATION (City or Town) (County) (State): 3801 Frederick Ave. Balto. Md.

24. FUNERAL DIRECTOR: Howard H. Hubbard, ADDRESS: 4107 Wilkens Ave. 21229
25a. REC'D BY REGISTRAR DATE: FEB 9 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

16

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01680 — 01677

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G. MEADE, MD
c. LENGTH OF STAY IN 1b: 50 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT GEORGE G. MEADE, MARYLAND
d. STREET ADDRESS: 7536 WILLS STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ESTHER — Middle L. — Last LUCAS

4. DATE OF DEATH: Month FEBRUARY — Day 25 — Year 1967

5. SEX: FEMALE

6. COLOR OR RACE: CAU

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 15 MARCH 1913

9. AGE (In years last birthday): 53 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): FORT CLINTON, OHIO(OHAWA)

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: HARRY H. KERR

14. MOTHER'S MAIDEN NAME: JESSIE PATTERSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: N/A

17. INFORMANT: UNKNOWN — 7536 WILLS STREET — CHARLES L. LUCAS(H) FT GEO G. MEADE, MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia with pneumonia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Invasive Squamous Cell Carcinoma of Cervix — 9 mos.
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from 6 Jan. ....., 19 67 to 25 Feb....., 19 67, that ☐ (we) last saw the deceased alive on 25 Feb 67 ..... 19 67, and that death occurred at 10:00 PM, from the causes and on the date stated above.

22a. SIGNATURE: Joseph S. Betts M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 25 Feb 67

22c. PHYSICIAN'S NAME (Type): JOSEPH S. BETTS, CPT, MC

22d. ADDRESS: KIMBROUGH ARMY HOSPITAL, FT GEO G. MEADE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: March 1, 1967

23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATINAL CEMETERY

23d. LOCATION (City, town or county): Ft. Myer, Virginia (State)

24 FUNERAL DIRECTOR'S SIGNATURE: Harold A. Wade

ADDRESS: Laurel, Maryland

25a. REC'D BY REGISTRAR DATE: MAR 2 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01681

CERTIFICATE OF DEATH

01678

1. PLACE OF DEATH
a. COUNTY - A.A. Co MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Knollwood Manor

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE MD b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD 2
d. STREET ADDRESS Hanover
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First JACKSON Middle Last LYONS

4. DATE OF DEATH Month 2 Day 3 Year 67 19

5. SEX M

6. COLOR OR RACE C

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH May 8, 1881

9. AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country) North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hem

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) A C VD

DUE TO (c) Senarit

4221

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 67, 19__ to 2-3-67, 19__, that (I) (we) last saw the deceased alive on Feb-67 19__, and that death occurred at 10 A.M., from the causes and on the date stated above.

22a. SIGNATURE Robert Holden M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) R. HAHN

22d. ADDRESS P.O. Box 73 Severna Park

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF 2-8-67

23c. NAME OF CEMETERY OR CREMATORY Rocky Mount Cem

23d. LOCATION (City, town or county) (State) Rocky Mount N.C.

24. FUNERAL DIRECTOR ADDRESS C.C. Stokes Funl Rocky Mount N.C.

25a. REC'D BY REGISTRAR DATE FEB 20 1967

25b. REGISTRAR'S SIGNATURE

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01682

CERTIFICATE OF DEATH

01679

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md.
   b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible] Severn [illegible] Park
   d. STREET ADDRESS: 276 Pertsch Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	James	Allen	Macey		Feb.	19	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		Feb. 19, 1967	yrs.		8 / 40

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Anne Arundel Co. [illegible]	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Albert Macey	Carol Irene Dail

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		Mother	276 Pertsch Rd. Severn Park Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY DISTRESS SYNDROME — INTERVAL BETWEEN ONSET AND DEATH: 8 1/2 40

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) PREMATURITY
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that (I) (this hospital) attended the deceased from 19 Feb, 1967, to 19 Feb, 1967, that (I) (we) last saw the deceased alive on 19 Feb 1967, and that death occurred at 9 P. M, from the causes and on the date stated above.

22a. SIGNATURE: Herman S Robinson M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 19 Feb 67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Cremation	2-24-67	North Arundel Hospital	Glen Burnie, Md. Hospital Drive,

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Alfred [illegible] Doran, Jr.	Administrator	2-[illegible]-67	Charles Judge

FEB 28 1967

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01683 — 01680

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: G.A. Co. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GEARBURNIE
   c. LENGTH OF STAY IN 1b: D.C.A
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. **USUAL RESIDENCE** (Where deceased lived, if institution: residence before admission)
   a. STATE: Md. — b. COUNTY: G.A. Co.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn, Md.
   d. STREET ADDRESS: 136 W B & A Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: ROBERT — Middle: LEE — Last: MELLAS

4. **DATE OF DEATH**: Month: Feb. — Day: 8 — Year: 1967

5. SEX: M. — 6. COLOR OR RACE: W — 7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: Apr. 25 1905 — 9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Iron Molder — 10b. KIND OF BUSINESS OR INDUSTRY: B. & O. Railroad — 11. BIRTHPLACE (County & State, or foreign country): W. Va. — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Mellas — 14. MOTHER'S MAIDEN NAME: Margaret Whitlock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No — 16. SOCIAL SECURITY NO.: 205-03-9330 — 17. INFORMANT: Mrs. Louise Mellas — Address: 136 W. B & A Rd. Severn Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Coronary attack — INTERVAL BETWEEN ONSET AND DEATH: Suddenly

DUE TO (b): Cardio Vascular Disease — 3 years

DUE TO (c): Emphysema — 4 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mental Incapacity 3 years — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/25/65 19..... to Feb 8 1967 19....., that (I) (we) last saw the deceased alive on Feb 6 1967 19....., and that death occurred at 7:30 AM, from the causes and on the date stated above.

22a. SIGNATURE OF PHYSICIAN: [signature] — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2/8/67

22c. PHYSICIAN'S NAME (Type): [illegible] M.D. — 22d. ADDRESS: Denton Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/11/67 — 23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem. — 23d. LOCATION (City, town or county) (State): Balto Md

24 FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: 901 Hollins St 21223 — 25a. REC'D BY REGISTRAR DATE: FEB 9 1967 — 25b. REGISTRAR'S SIGNATURE: [signature] Judge

VR A15 (1) 20M S-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01684

CERTIFICATE OF DEATH

01681

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M S-63

1. **PLACE OF DEATH**
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT GEORGE G. MEADE
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE - Dundalk
d. STREET ADDRESS: 6928 Sollers Point Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: ROBERT — Middle: JOSEPH — Last: MESARIS

4. **DATE OF DEATH**: Month: FEBRUARY — Day: 21 — Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: CAU

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 13 FEB 22

9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S.Army Retired

10b. KIND OF BUSINESS OR INDUSTRY: Serviceman

11. BIRTHPLACE (County & State, or foreign country): Pittston, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Andrew Mesaris

14. MOTHER'S MAIDEN NAME: Caroline Hoffman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes 1940-1Sep62

16. SOCIAL SECURITY NO.: 182-16-7165

17. **INFORMANT**: Rebecca L.Mesaris, 6928 Sollers Point Rd — Address: Baltimore, Md

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 2 HOURS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town, (County) (State)

21. **I certify** that ~~(I) (this hospital) attended~~ the deceased ~~was~~ WAS DOA ~~on~~ ..., 19X..., ~~last seen alive on~~ X 21 Feb ..., 19 67 that ~~(I) (we) last saw~~ ~~the deceased alive on~~ 19X....., and that death occurred at 2:25 .....M, from the causes and on the date stated above.

22a. SIGNATURE: Joseph C DiMarco M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 21 Feb 67

22c. PHYSICIAN'S NAME (Type): JOSEPH C.DiMARCO

22d. ADDRESS: KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD

23a. BURIAL, CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/24/67

23c. NAME OF CEMETERY OR CREMATORY: Loudon Park National Cem.

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Duda 7922 Wise Ave. Dundalk, Md. 21222

25a. RECD BY REGISTRAR DATE: FEB 24 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01685 01682

1. PLACE OF DEATH
a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 49 W. Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Sarah Middle Blaney Last MILLER
4. DATE OF DEATH: Month February Day 1 Year 1967
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: November 17, 1894
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 218-14-2255
17. INFORMANT: James A. Wellis Address: Annapolis Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): H.T.N.C.V.D — 4 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 443X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 28 19 67 to Feb 1, 1967, that (I) (we) last saw the deceased alive on Feb 1 19 67, and that death occurred at 2:25 A.M. from causes and on the date stated above

22a. SIGNATURE: Faye W Allen M.D ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2/1/67
22c. PHYSICIAN'S NAME (Type): Faye W Allen
22d. ADDRESS: 62 Cathedral St Annapolis Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-4-1967
23c. NAME OF CEMETERY OR CREMATORY: St Anns
23d. LOCATION (City or Town) (County) (State): Annapolis Md.

24. FUNERAL DIRECTOR: William Reiser ADDRESS: Annapolis Md.
25a. RECD BY REGISTRAR DATE: Feb 2 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01686

CERTIFICATE OF DEATH

01683

1. PLACE OF DEATH
a. COUNTY: AA.
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bay Ridge Ave

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
d. STREET ADDRESS: R.D. -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Caroline Middle: E. Lost: Myers.

4. DATE OF DEATH: Month: 2 Day: 16 Year: 67 19

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/17/93

9. AGE (Last birthday): 73 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, if foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family - Same
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: 4 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): (1) Pagets disease of bone (2) arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/30/65, 19__, to 1/31, 1967, that (I) (we) last saw the deceased alive on 1/31, 19 67, and that death occurred at ____M, from causes and on the date stated above.

22a. SIGNATURE: Ray M. Smith M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Ray M. Smith, M.D.

22d. ADDRESS: Hahn Professional Building, Sev. Pk., Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/20/67

23c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn

23d. LOCATION (City or Town) (County) (State): Balt.

24. FUNERAL DIRECTOR: A. Carey - 737 Talbot
ADDRESS

25a. REC'D BY REGISTRAR
DATE FEB 21 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Juoga

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01687 01684

Item 4 Claim 6686 2/24/67 mh

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 19 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 111 Fourth Ave, S/E

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 111 Fourth Ave, S/E
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HELENA Middle BERTHA Last NAUMANN

4. DATE OF DEATH: Month 2 Day 16 Year 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/6/84
9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Baker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (Kriewald)
14. MOTHER'S MAIDEN NAME: Louisa Lehr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-54-1192
17. INFORMANT: Address: Jl (Louise Kressler - Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 9 min

DUE TO (b): Arteriosclerotic Heart Disease — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Generalized Arteriosclerosis — 15 yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive Heart Failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/10, 19 67 to 2/18, 19 67, that (I) (we) last saw the deceased alive on 2/18 19 67, and that death occurred at 1 P.M., from the causes and on the date stated above.

22a. SIGNATURE: R. W. Prichard M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2/17/67
22c. PHYSICIAN'S NAME (Type): R. W. PRICHARD MD
22d. ADDRESS: Glen Burnie, Maryland

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/20/67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town, or county) (State): Brooklyn Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: R. Swan ADDRESS: Singleton Funeral Home/ Glen Burnie, Md,
25a. REC'D BY REGISTRAR DATE: FEB 20 1967
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2M M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01688

CERTIFICATE OF DEATH

01685

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Norht Arundel Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
d. STREET ADDRESS: Rt #2 Box 89 Reese Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Vernon — Middle: Roland — Last: Norris

4. DATE OF DEATH: Month: February — Day: 5 — Year: 19 67

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 25, 1909

9. AGE (In years last birthday): 57 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter (ret)

10b. KIND OF BUSINESS OR INDUSTRY: Const.

11. BIRTHPLACE (County & State, or foreign country): Gaithersburg, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: (unknown) Balton

14. MOTHER'S MAIDEN NAME: Oella (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Address: 28 Perndale Ave. — Mrs. Deanna M. Nehring Glen Burnie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Coronary attack — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Chronic Myocarditis — 2 yrs
DUE TO (c): Emphysema
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 3, 1966 to Feb 3, 67, that (I) (we) last saw the deceased alive on Feb 3 1967, and that death occurred at — M, from causes and on the date stated above.

22a. SIGNATURE: Joseph Linskey M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/7/67

22c. PHYSICIAN'S NAME (Type): JOSEPH LINSKEY

22d. ADDRESS: TELEGRAPH ROAD, SEVERN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 8, 1967

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem'l Park

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR: R.V. SINGLETON — ADDRESS: GLEN BURNIE, MD.

25a. REC'D BY REGISTRAR DATE: FEB 10 1967

25b. REGISTRAR'S SIGNATURE: Julia S. Riggs

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death (Page 4 may be retained by the hospital ■ attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01689

CERTIFICATE OF DEATH

01686

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 1210 Sterling Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle Louis — Last NORTON
4. DATE OF DEATH: Month February — Day 2 — Year 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 10, 1901
9. AGE (In years last birthday): 65 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONTRACTOR
10b. KIND OF BUSINESS OR INDUSTRY: BUILDING
11. BIRTHPLACE (County & State, or foreign country): BALTO. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOHN L. NORTON
14. MOTHER'S MAIDEN NAME: ? GALT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: MAUDE B. NORTON # 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) the ~~hospital~~ attended the deceased from 8/16, 1966, to Feb. 2, 1967, that (I) ☒ last saw the deceased alive on Feb. 2, 19 67 and that death occurred at 12:20 PM from causes and on the date stated above.

22a. SIGNATURE: Richard I. Hochman M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2/3/67
22c. PHYSICIAN'S NAME (Type): Richard I. Hochman, M.D.
22d. ADDRESS: 59 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2-4-1967
23c. NAME OF CEMETERY OR CREMATORY: HILLCREST MEM. CEM.
23d. LOCATION (City or Town) (County) (State): ANNAPOLIS AA. Co. MD

24. FUNERAL DIRECTOR: JOHN M. TAYLER SONS — ADDRESS: ANNAPOLIS MD.
25a. REC'D BY REGISTRAR DATE: FEB 8 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01690 01687

1. PLACE OF DEATH
a. COUNTY A-A
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis Md
c. LENGTH OF STAY IN 1b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) BAY MANOR Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md. b. COUNT Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park 21146
d. STREET ADDRESS 101 Linda Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ELSIE Middle J. Last OGLE

4. DATE OF DEATH Month 2 Day 8 Year 67

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH Feb. 23, 1884.

9. AGE (In years last birthday) 82 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country) Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME August Bartholomew

14. MOTHER'S MAIDEN NAME Sybilla Dietz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No (If yes give war or dates of service)

16. SOCIAL SECURITY NO. 212-54-9746J1

17. INFORMANT Mrs. Julia O. Saunders Address (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): myocardial infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1
DUE TO (b): A C V D
DUE TO (c): Senility

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1959, 19__, to 1967, 19__, that (I) (we) last saw the deceased alive on 2-1-67 19__, and that death occurred at __M, from the causes and on the date stated above.

22a. SIGNATURE Robert R. Hahn M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) Robert R HAHN

22d. ADDRESS P.O. Box 73 Severna Park

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF 2/11/67.

23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery

23d. LOCATION (City, town or county) (State) Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214

25a. REC'D BY REGISTRAR DATE FEB 10 1967

25b. REGISTRAR'S SIGNATURE [illegible] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in particular Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A1SME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film [illegible] 2/14/67 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01691 — 01688

1 PLACE OF DEATH
a COUNTY: A.A.Co. — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Ridge Road

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: MD — b COUNTY: AACo
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenburnie
d STREET ADDRESS: Ridge Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Harold — Middle: E — Last: Peterson
4 DATE OF DEATH: Month: Y — Day: 9 — Year: 1967
5 SEX: M
6 COLOR OR RACE: W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 9/2/1938
9. AGE (In years last birthday): 17 11/28 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b KIND OF BUSINESS OR INDUSTRY: Construction
11 BIRTHPLACE (State or foreign country): Florida
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Gordon Peterson
14 MOTHER'S MAIDEN NAME: ? Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes — (If yes give war or dates of service): 1956-1964
16 SOCIAL SECURITY NO.: 472347315
17 INFORMANT: Mrs. Edith M. Peterson — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Gun Shot Wound Skull — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Self inflicted Gun Shot Wound
20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m.: 6 2/0 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f (City or town) (County) (State): AACo MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt M D
EXAMINER'S NAME (Type): E. Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 2/9/67

23a BURIAL CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 2/13/67
23c NAME OF CEMETERY OR CREMATORY: Balto. Natl Cemetery
23d LOCATION (City or Town) (County) (State): Balto. Maryland

24 FUNERAL DIRECTOR: Leonard J. Ruck Inc. — ADDRESS: 5305 Harford Rd.
25a RECD BY REGISTRAR DATE: FEB 14 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01692

CERTIFICATE OF DEATH

01689

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Annapolis
d. STREET ADDRESS: 3 Riverview Ave., Weems Creek
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Nick; Middle: Joseph; Last: POCHATKO
4 DATE OF DEATH: Month: February; Day: 22; Year: 19 67
5 SEX: Male
6. COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 11-6-1905
9 AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): PAINTER
10b KIND OF BUSINESS OR INDUSTRY: Painting
11 BIRTHPLACE (County & State, or foreign country): NANTICOKE, Pennsylvania
12 CITIZEN OF WHAT COUNTRY? U.S.
13 FATHER'S NAME: ELIAS POCHATKO
14 MOTHER'S MAIDEN NAME: ANNA STRELLA
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO:
17. INFORMANT: THOMAS POCHATKO — Address: #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Extreme Cachexia + malnourishment — INTERVAL BETWEEN ONSET AND DEATH: months
DUE TO (b): Obstruction Oral cavity — months
DUE TO (c): Squamous cell Carcinoma oral cavity — 1 year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Note point of origin of Carcinoma unknown
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) ~~(the physician)~~ attended the deceased from 2-15, 1967, to Feb. 22, 1967, that (I) ~~(we)~~ last saw the deceased alive on Feb. 22, 1967, and that death occurred at 1:30 AM, from causes and on the date stated above.

22a SIGNATURE: Peter F. Verkouw, M.D. — ATTENDING PHYS XX MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 2-22-67
22c. PHYSICIAN'S NAME (Type): Peter F. Verkouw, M.D.
22d. ADDRESS: 1407 Forest Drive, Annapolis, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-24-67
23c. NAME OF CEMETERY OR CREMATORY: St. Marys
23d. LOCATION (City or Town) (County) (State): Annapolis MD.
24 FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.
25a RECD BY REGISTRAR DATE: FEB 28 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

C1683 — 01690

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 104 Claude St.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 104 CLAUDE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First CAROLINE — Middle BEATRICE — Last REHN

4. DATE OF DEATH: Month FEB, Day 12, Year 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8 DATE OF BIRTH: 12/27/05

9 AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERICAL

10b KIND OF BUSINESS OR INDUSTRY: State

11 BIRTHPLACE (County & State, or foreign country): ANNE ARUNDEL, MD.

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: GEORGE ROBERT MITCHELL

14. MOTHER'S MAIDEN NAME: LILLIAN AUGUSTA HALL

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service)

16 SOCIAL SECURITY NO: 213-14-3573

17 INFORMANT: Alvin A. Redd, Jr. Husband — Address: Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): METASTASES — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) CARCINOMA OF SIGMOID COLON — 4 years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from DEC. , 1966 to _____, 19___, that (I) (we) last saw the deceased alive on _____ 19___, and that death occurred at 9 A.M. from causes and on the date stated above.

22a. SIGNATURE: Jesse L. Wilkins — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c PHYSICIAN'S NAME (Type): JESSE L. WILKINS

22d. ADDRESS: 98 Cathedral St, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: Feb. 15, 1967

23c NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery

23d. LOCATION (City or Town) (County) (State): Annapolis A.A. Md.

24 FUNERAL DIRECTOR: Beverley E. Hopping — HOPPING FUNERAL HOME — ADDRESS: Beverley E. Hopping, Annapolis, Md.

25a. REC'D BY REGISTRAR DATE FEB 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01694

CERTIFICATE OF DEATH

01691

1. PLACE OF DEATH
   a. COUNTY: ANNE ARUNDEL
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
   c. LENGTH OF STAY IN 1b: 30 YEARS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. NAVAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ANNE ARUNDEL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
   d. STREET ADDRESS: 24 BOXWOOD RD. ANNA. MD.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY Middle KENNETH Last RICHARDSON

4. DATE OF DEATH: Month FEBRUARY Day 5 Year 1967

5. SEX: MALE

6. COLOR OR RACE: CAU.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 20 NOV. 1901

9. AGE (In years last birthday): 65 yrs.
   IF UNDER 1 YEAR: Months ___ Days ___
   IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MASTER AT ARMS NAVAL ACAD.

10b. KIND OF BUSINESS OR INDUSTRY: CIVIL SERVICE

11. BIRTHPLACE (County & State, or foreign country): SANTA BARBARA, CALIF.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNK.

14. MOTHER'S MAIDEN NAME: UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES (If yes give war or dates of service): 1939-1945

16. SOCIAL SECURITY NO.: 216-44-5749

17. INFORMANT: ELSIE MARIE RICHARDSON Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Rupture of AORTIC ANEURYSM — INTERVAL BETWEEN ONSET AND DEATH: Immediate

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): generalized arteriosclerosis
DUE TO (c): hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Obstructive Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5 FEB, 19 67 PM to 5 FEB, 19 67, that (I) (~~last~~ saw the deceased alive on 5 FEB 1967, and that death occurred at 5:21 M, from the causes and on the date stated above.

22a. SIGNATURE: Roger M F Smith M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: FEB 5, 67

22c. PHYSICIAN'S NAME (Type): Roger M. F. SMITH, LT MC, USN

22d. ADDRESS: U. S. Naval Hospital, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-8-67

23c. NAME OF CEMETERY OR CREMATORY: GLEN HAVEN

23d. LOCATION (City, town or county) (State): GLEN BURNIE MD.

24. FUNERAL DIRECTOR: John M. Taylor Sons

ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: FEB 8 1967

25b. REGISTRAR'S SIGNATURE: J Charles Jr

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01695

CERTIFICATE OF DEATH

01692

1 PLACE OF DEATH
a. COUNTY: Annapolis — A.A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 33 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Annapolis
d. STREET ADDRESS: Loretta Heights
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Daisy — Middle: (none) — Last: RIGGINS
4. DATE OF DEATH: Month: February — Day: 12 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 29, 1886
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOSEPH DAVIDSON
14. MOTHER'S MAIDEN NAME: ? DAVIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: WALTER W. RIGGINS #2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Stroke
DUE TO
(b): Hypertension — yrs
~~DUE TO~~
(c): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
IX

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (~~has treated~~) attended the deceased from Jan. 10, 19 67, to Feb. 12, 19 67, that (I) (~~he~~) last saw the deceased alive on Feb. 12, 19 67, and that death occurred at 3:55 PM, from causes and on the date stated above.

22a. SIGNATURE: Frank Shipley — M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2-13-67
22c. PHYSICIAN'S NAME (Type): F.M. SHIPLEY
22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2-15-1967
23c. NAME OF CEMETERY OR CREMATORY: HILLCREST CEM.
23d. LOCATION (City or Town) (County) (State): ANNAPOLIS MD.

24. FUNERAL DIRECTOR: JOHN M. TAYLOR SON — ADDRESS: ANNAPOLIS MD
25a. REC'D BY REGISTRAR DATE: FEB 14 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01686

CERTIFICATE OF DEATH

01693

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 146 O'bery Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Henry — Last: Robinson, Jr.

4. DATE OF DEATH: Month: 2 — Day: 7 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 22, 1951

9. AGE (In years last birthday): 15 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: -------

11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Robinson, Sr.

14. MOTHER'S MAIDEN NAME: Standola Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: John H. Robinson, Sr. — Address: 146 O'bery Ct. Md. Anna.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Hypostatic Pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/26, 19 66, to 2/7, 1967, that (I) (we) last saw the deceased alive on 2/7 19 67, and that death occurred at 6:10 AM, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 2/7/67

22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-11-67

23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

23d. LOCATION (City or Town) (County) (State): Annapolis A.A. Md

24. FUNERAL DIRECTOR: C.E. Hicks, III — ADDRESS: Annapolis, Md

25a. REC'D BY REGISTRAR DATE: FEB 14 1967

25b. REGISTRAR'S SIGNATURE: [signature] Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01687 — 01694

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 1220 McKinley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
LEWIS	LAMBDIN	ROBINSON	February	11	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Cauc	MARRIED ☒	27 January 1909	58 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
U. S. Navy	Ret.	Baltimore, Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Oscar Robinson	Henrietta Lambdin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address	
Yes WWII - KOREA	219-34-0716	Mrs. E.M. Robinson	1220 McKinley St. Annapolis, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Infarction	
4201 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	16 yrs
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that (I) (this hospital) attended the deceased from 11 Feb, 19 67, to 11 Feb., 19 67, that (I) (we) last saw the deceased alive on 11 February 1967, and that death occurred at 8:20 AM, from the causes and on the date stated above.

22a. SIGNATURE: Barry John Coughlin M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 11 Feb. 1967

22c. PHYSICIAN'S NAME (Type): Barry John Coughlin — 22d. ADDRESS: Naval Hospital, Annapolis, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	2-15-67	Arlington Nat'l.	Arlington Va.

24. FUNERAL DIRECTOR: John M. Layla + Sons — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: FEB 15 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01688

CERTIFICATE OF DEATH

01695

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 5 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 4213 Mary Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) #33332 — First: Alberta — Middle: A. — Last: Ronspies

4. DATE OF DEATH — Month: 2 — Day: 17 — Year: 19 67

5 SEX: Female

6 COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/15/ 1900

9. AGE (In years last birthday): 66 ~~65~~ yrs

IF UNDER 1 YEAR — Months: Days: IF UNDER 24 HRS — Hours: Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Housewife~~ Retired

10b KIND OF BUSINESS OR INDUSTRY: Bromo Seltzer Co.

11 BIRTHPLACE (County & State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert ~~xx~~ Ronspies

14. MOTHER'S MAIDEN NAME: Anna Taylor ~~xxAlberta~~

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO. 217-22-6113 ~~xxxxxxxx~~

17 INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Confluent Bronchopneumonia, Bilateral
DUE TO
Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse last.
(b) Rheumatic Heart Disease
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Old Myocardial Infart; TBC-Right Lung, Inanition

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/19/ 19 66 to 2/17/ 19 67, that (I) (we) last saw the deceased alive on 2/17/ 19 67, and that death occurred at 8:00 M, from couses and on the date stated above.

22a SIGNATURE: L. Benedict M.D.

M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☒ STAFF PHYS ☐

22b. DATE SIGNED: 2/17/67

22c. PHYSICIAN'S NAME (Type): L. Benedict, M.D.

22d. ADDRESS: Crownsville State Hospital, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 2/21/67.

23c NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

23d LOCATION (City or Town) (County) (State): Washington, D.C.

24 FUNERAL DIRECTOR — ADDRESS: Leonard J. Ruck, Inc. Balto. Md. 21214

25a. REC'D BY REGISTRAR DATE: FEB 20 1967

25b REGISTRAR'S SIGNATURE: Charles Jones

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01699

CERTIFICATE OF DEATH

01696

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 2 3/8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
d. STREET ADDRESS: Rt.2 Bahama Beach
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby Michele — Middle: S. — Last: Scarlett
4. DATE OF DEATH: Month: 2 — Day: 20 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-17-67
9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Anne Arundel, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas Bruce Scarlett
14. MOTHER'S MAIDEN NAME: Darlene Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT — Address: Mother"s chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 773.5 — Respiratory distress Syndrome (Hyaline membrane)
DUE TO (b):
DUE TO (c): Prematurity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 1½ days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/17/67, 19__, to 2/20/67, 19__, that (I) (we) last saw the deceased alive on 2/20/67 19__, and that death occurred at 3A M, from causes and on the date stated above.

22a. SIGNATURE: S. Munsters M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/20/67
22c. PHYSICIAN'S NAME (Type): Silvino B. Munsters
22d. ADDRESS: 5004 Ritchie Hwy

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2 21 67
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven
23d. LOCATION (City or Town) (County) (State): Glen Burnie, A. A. Co. Md

24. FUNERAL DIRECTOR: Mc Cully
ADDRESS: 130 . Fort Ave
25a. REC'D BY REGISTRAR DATE: FEB 23 1967
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01700

CERTIFICATE OF DEATH

01697

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 43yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 8 Ferdinand Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Ferndale) Glen Burnie
d. STREET ADDRESS: 8 Ferdinand Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARIE; Middle; Last SCHAEFFER

4. DATE OF DEATH: Month February; Day 19; Year 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 11, 1892
9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis Suffner
14. MOTHER'S MAIDEN NAME: (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 214-01-7056-B
17. INFORMANT: John C. Schaeffer (Husband) Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebro-Vascular Accident
DUE TO: Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO:
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 1967, to Feb. 18, 1967, that (I) (we) last saw the deceased alive on Feb. 19, 1967, and that death occurred at 2:00 PM, from causes and on the date stated above

22a. SIGNATURE: Lynn Saulpaugh M.D
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Lynn Saulpaugh, M.D.
22d. ADDRESS: 1 Old Annapolis Rd., Ferndale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 22, 1967
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.
23d. LOCATION (City or Town) (County) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR: Richard V. Singleton
ADDRESS: Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE: FEB 24 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01701 01698

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade, Md.
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kimbrough AH Ft Geo g Meade, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: OHIO — b. COUNTY: JEFFERSON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mingo Junction
d. STREET ADDRESS: 316 Carlisle Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PAUL — Middle ALLEN — Last SCHAYES

4. DATE OF DEATH: Month February — Day 2 — Year 19 67

5. SEX: Male
6. COLOR OR RACE: Cau
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8 December 1945
9. AGE (In years last birthday): 21 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Army
11. BIRTHPLACE (County & State, or foreign country): Jeffersen, Ohio
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ernest Theodore Schayes
14. MOTHER'S MAIDEN NAME: Pearl Imogene Malone

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): 1965-1967
16. SOCIAL SECURITY NO.: 263-44-3289
17. INFORMANT: Ernest Schayes (F) — Address: 316 Carlisle Ave Mingo Junction, Ohio

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Rheumatic Pancarditis	16 Jan 67
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Acute Recurrent Rheumatic Fever	2 Feb 67
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~DECEASED~~) attended the deceased from 16 Jan 67, 19__, to 2 Feb 67, 19__, that (I) (~~WAS~~) last saw the deceased alive on 2 Feb 19 67, and that death occurred at 9:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Lynn W. Holder M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 2 February 1967
22c. PHYSICIAN'S NAME (Type): LYNN W. HOLDER, CPT, MC
22d. ADDRESS: KIMBROUGH AH, FT GEO G. MEADE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: Feb.6, 1967
23c. NAME OF CEMETERY OR CREMATORY: Ft. Steuben Cemetery
23d. LOCATION (City, town or county) (State): Steubenville, Ohio

24. FUNERAL DIRECTOR'S SIGNATURE: Harvey L. Wade — ADDRESS: Laurel, Maryland
25a. REC'D BY REGISTRAR DATE: FEB 8 1967
25b. REGISTRAR'S SIGNATURE: Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01702

CERTIFICATE OF DEATH

01699

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 1206 West St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Robert — Middle Henry — Last SCIBLE
4. DATE OF DEATH: Month February — Day 19 — Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 5, 1888
9. AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): District Manager
10b. KIND OF BUSINESS OR INDUSTRY: Ins. Co.
11. BIRTHPLACE (County & State, or foreign country): Annapolis Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: William Taylor Scible
14. MOTHER'S MAIDEN NAME: Emma Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Nettie S. Carr — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of esophagus with — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): cerebral metastasis — 2 mos
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~his knowledge~~) attended the deceased from _____, 19__, to Feb. 19, 19 67, that (I) (~~he~~) last saw the deceased alive on Feb. 19 19 67, and that death occurred at 7:15 AM, from causes and on the date stated above.

22a. SIGNATURE: Richard I. Peeler — M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2-20-67
22c. PHYSICIAN'S NAME (Type): Richard I. Peeler
22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-22-67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff
23d. LOCATION (City or Town) (County) (State): Annapolis A.A. Md.
24. FUNERAL DIRECTOR: John M. Taylor Sons
ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: FEB 21 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01703

CERTIFICATE OF DEATH

01700

1. PLACE OF DEATH
a. COUNTY: H-A-Co. — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SEVERNA PARK
c. LENGTH OF STAY IN 1b: 11 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 20 HATTON Dr.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEVERNA PARK
d. STREET ADDRESS: 20 HATTON Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SOPHIE Middle M. Last SHEATS
4. DATE OF DEATH: Month 2 Day 2 Year 1967
5. SEX: FEM.
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-2-83
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: @ home
11. BIRTHPLACE (County & State, or foreign country): BALTO MD
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Otto WIESENBACH
14. MOTHER'S MAIDEN NAME: MARY WEBER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Leroy Sheats — Address: - Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ruptured abdominal Aneurysm
451X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): ASCVD
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ___, 1952 to Feb 3rd, 1967, that (I) (we) last saw the deceased alive on February 1 1967, and that death occurred at 5:00 PM, from the causes and on the date stated above.

22a. SIGNATURE: Newland E. Day M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: February 3, 1967
22c. PHYSICIAN'S NAME (Type): NEWLAND E DAY
22d. ADDRESS: 4-E-33rd St Balt

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/6/67
23c. NAME OF CEMETERY OR CREMATORY: Loudon Park
23d. LOCATION (City, town or county): Balto (State): Md

24. FUNERAL DIRECTOR: Robert S. Barranco
ADDRESS: Severna Pk. Md
ROBERT S. BARRANCO

25a. REC'D BY REGISTRAR DATE: FEB 7 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) - 20M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01704

CERTIFICATE OF DEATH

01701

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 5 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn 02-1
d. STREET ADDRESS: 108 Dension Drive
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Albert — Middle: Gary — Last: Shifflett
4. DATE OF DEATH: Month: February — Day: 14 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 3, 1952
9. AGE (In years last birthday): 14 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: School
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert M. Shifflett
14. MOTHER'S MAIDEN NAME: Josie B. Sullivan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — None
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: MR. Albert M. Shifflett (Father) Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Left ventricular failure — INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO (b): Acute Pulmonary edema — days
DUE TO (c): Essential hypertension — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
44 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congenital heart disease.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/10, 1967, to 2/14 1967, that (I) (we) last saw the deceased alive on 2/14 1967, and that death occurred at 9:24 A.M., from causes and on the date stated above

22a. SIGNATURE: Max C Frankland M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ Acty
22b. DATE SIGNED: 2/14/67
22c. PHYSICIAN'S NAME (Type): MAX C FRANKLAND
22d. ADDRESS: 425 SE RITCHIE Hwy Glen Burnie

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb 17, 1967
23c. NAME OF CEMETERY OR CREMATORY: Hillsboro Cemetery
23d. LOCATION (City or Town) (County) (State): Crozet, Virginia

24. FUNERAL DIRECTOR — ADDRESS: Richard V. Singleton, Glen Burnie, Md.
25a. REC'D BY REGISTRAR — DATE: FEB 16 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01705

CERTIFICATE OF DEATH

01702

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (R)
25M 1/67

1. PLACE OF DEATH — a. COUNTY: A.A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS, MD.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A.A. General Hosp. D.O.A.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: M.D. — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Margarets
d. STREET ADDRESS: R.F.D. Box 283
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: BERTHA — Middle: — Last: SMITH
4. DATE OF DEATH: Month: 2 — Day: 25 — Year: 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8-28-1891
9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (County & State or foreign country): WARSAW POLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Paul Kucinski
14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mary L. Windsor — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Coronary Thrombosis ?
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: D.O.A.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes ?
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-9 1966 to 2-25 1967 that (I) (we) last saw the deceased alive on 2-19 1967, and that death occurred at 12:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: F.M. Shipley — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2-27-67
22c. PHYSICIAN'S NAME (Type): F.M. SHIPLEY
22d. ADDRESS: Annapolis Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2-28-67
23c. NAME OF CEMETERY OR CREMATORY: St. Stanislaus
23d. LOCATION (City or Town) (County) (State): Balto. MD.

24. FUNERAL DIRECTOR — ADDRESS: John M. Taylor Sons Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: FEB 28 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01706

CERTIFICATE OF DEATH

01703

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bristol
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bristol — Maryland
d. STREET ADDRESS: —
e. RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Vernie — Middle: — Last: Smith

4 DATE OF DEATH: Month: Feb — Day: 14 — Year: 1967

5 SEX: M

6 COLOR OR RACE: N

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Sept 2, 1887

9 AGE (In years last birthday): 79 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11 BIRTHPLACE (County & State, or foreign country): Anne Arundel Md

12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: John Smith

14 MOTHER'S MAIDEN NAME: Julie Howard

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16 SOCIAL SECURITY NO

17. INFORMANT: Nellie Brice, Address: Bristol Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Arteriosclerotic Heart Disease — Years
DUE TO (c): Generalized Arteriosclerosis — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MED. EX. EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): No Accident

20c TIME OF INJURY Month, Day, Year Hour o m p.m. — 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from Nov, 1966 to Feb, 1967 that (I) (~~we~~) last saw the deceased alive on Feb 1967, and that death occurred at 10:45 A.M. from causes and on the date stated above.

22a. SIGNATURE: Charles H. Wirth MD — M.D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED: Feb 14, 67

22c. PHYSICIAN'S NAME (Type): Charles H. Wirth, M.D

22d ADDRESS: Lothian, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 2-18-1967

23c NAME OF CEMETERY OR CREMATORY: Dixie

23d LOCATION (City or Town) (County) (State): Harwood

24 FUNERAL DIRECTOR: William Beard (Lic. #) — ADDRESS:

25a. REC'D BY REGISTRAR DATE FEB 15 1967

25b REGISTRAR'S SIGNATURE: Charles Yingo

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01707

CERTIFICATE OF DEATH

01704

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 mo. 10 da.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
d. STREET ADDRESS: Box-257S
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Roland — Middle: Thomas — Last: SOMERS

4. DATE OF DEATH: Month: February — Day: 3 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 20, 1901

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BUILDER-CONTRACTOR

10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION

11. BIRTHPLACE (County & State, or foreign country): DORCHESTER Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: CALWOOD S. SOMERS

14. MOTHER'S MAIDEN NAME: MOLLIE DUNCAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO:

17. INFORMANT: BLANCHE BOZMAN SOMERS — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: Unk.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Emphysema, Cor pulmonale with failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(X box)~~ attended the deceased from _____, 19 67, to Feb. 3, 19 67 that (I) (~~X~~) last saw the deceased alive on Feb. 3, 19 67, and that death occurred at 7:50 AM M, from causes and on the date stated above

22a. SIGNATURE: Richard N. Peeler, M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 2-4-1967

22c. PHYSICIAN'S NAME (Type): RICHARD N. PEELER

22d. ADDRESS: 121 CATHEDRAL ST. ANNAPOLIS MD.

23a. BURIAL CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2-6-1967

23c. NAME OF CEMETERY OR CREMATORY: SPRING HILL CEM.

23d. LOCATION (City or Town) (County) (State): EASTON MD

24. FUNERAL DIRECTOR: JOHN M. TAYLOR-SONS — ADDRESS: ANNAPOLIS MD.

25a. REC'D BY REGISTRAR DATE: FEB 8 1967

25b. REGISTRAR'S SIGNATURE: Mildred J. Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

Items 18-21 Film 386 3-16

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MAR 16 1967

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01708

01705

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 16 East Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: No — Last: SPRINGFIELD

4. DATE OF DEATH: Pronounced — Month: February — Day: 25, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 3-21-1900

9. AGE (In years last birthday): 66 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.

10b. KIND OF BUSINESS OR INDUSTRY: City Fire Dept.

11. BIRTHPLACE (State or foreign country): Benedict, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George W. A. Springfield

14. MOTHER'S MAIDEN NAME: Annie Laurie Constance

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): -

16. SOCIAL SECURITY NO:

17. INFORMANT: Frances Springfield — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowning
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Found in water, presumably drowned

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m.: Unknown 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): water

20f. (City or town): Annapolis — (County): A A — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M D

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county):

22. DATE SIGNED: February 26, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-28-67

23c. NAME OF CEMETERY OR CREMATORY: St. Annes

23d. LOCATION (City or Town): Annapolis — (County): A.A. — (State): Md.

24. FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis Md.

25a. REC'D BY REGISTRAR DATE: FEB 28 1967

25b. REGISTRAR'S SIGNATURE: J. Claude Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (6) 6M 1/67

1 (M)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01709

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01706

1. PLACE OF DEATH
a. COUNTY: A.A. Co
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PASADENA
c. LENGTH OF STAY IN MARYLAND: 6 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5 S. RITCHIE Hwy

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: A.A. Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PASADENA
d. STREET ADDRESS: 5 S. RITCHIE Hwy
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RUTH Middle ANN Last STEWART

4. DATE OF DEATH: Month 2 Day 3 Year 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-28-11

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WAITRESS

10b. KIND OF BUSINESS OR INDUSTRY: RESTAURANT

11. BIRTHPLACE (State or foreign country): NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: ___ EDWARDS

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ___

16. SOCIAL SECURITY NO.: 530141571

17. INFORMANT: EPHRAIM STEWART (HUSBAND) Address: - ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerosis [illegible]

DUE TO (b): ___

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): ___

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): [illegible]

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): E Linhardt M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): [illegible]

DATE SIGNED: 2-5-67

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2-6-67

22c. NAME OF CEMETERY OR CREMATORY: MEADOWRIDGE CEM.

22d. LOCATION (City, town, or county): DORSEY (State) Md

23. FUNERAL DIRECTOR: Robert S. Barranco ADDRESS: Severna Pk. Md

ROBERT S. BARRANCO

24a. REC'D BY REGISTRAR DATE: FEB 7 1967

24b. REGISTRAR'S SIGNATURE: [signature] Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01710

CERTIFICATE OF DEATH

01707

PLACE OF DEATH
a COUNTY: A A Co — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a STATE: Md — b COUNTY: A A Co.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater, Md
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☑ NO ☐

3 **NAME OF DECEASED** (Type or print): First: James — Middle: Austin — Last: STUART

4 **DATE OF DEATH**: Month: 2 — Day: 8 — Year: 1967

5 SEX: Male
6 COLOR OR RACE: white
7 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: March 1, 1899
9 AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): C S P C
10b KIND OF BUSINESS OR INDUSTRY: Government
11 BIRTHPLACE (County & State, or foreign country): Spokane, Washington
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: James Wiley Stuart
14 MOTHER'S MAIDEN NAME: Effie LaRue

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service):
16 SOCIAL SECURITY NO: 220-44 6649
17 INFORMANT: Stella Cook Stuart — Address: Edgewater, Md

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO
(b): coronary artery disease
DUE TO
(c): hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-8, 1967, to 2-8, 1967, that (I) (we) last saw the deceased alive on 2-8 1967, and that death occurred at _____ M. from causes and on the date stated above.

22a. SIGNATURE: Emily H. Wilson — M.D. ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-9-67
22c. PHYSICIAN'S NAME (Type): Emily H. Wilson, M.D.
22d. ADDRESS: Lothian, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb 11, 1967
23c. NAME OF CEMETERY OR CREMATORY: U.S. Naval Cemetery
23d. LOCATION (City or Town) (County) (State): Annapolis Md

24 FUNERAL DIRECTOR: T S Hardesty — ADDRESS: 12 E. Dayton Ave Annapolis Md
25a REC'D BY REGISTRAR DATE: FEB 14 1967
25b REGISTRAR'S SIGNATURE: J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01711

CERTIFICATE OF DEATH

01708

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Annapolis
d. STREET ADDRESS: Rt-1, Box-23
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: William — Middle: Thomas — Last: TAPP
4. DATE OF DEATH: Month: February — Day: 1 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Oct. 1, 1902
9. AGE (In years last birthday): 64 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: DAIRY
11. BIRTHPLACE (County & State or foreign country): Culpepper, Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: GEORGE E. TAPP
14. MOTHER'S MAIDEN NAME: ALLMIRE C. BROWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: IRENE TAPP #2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of the prostate
19. WAS AUTOPSY PERFORMED? YES [XX] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~XXXXXXX~~) attended the deceased from Dec. 20, 19 66, to Feb. 1, 19 67, that (I) (~~XX~~) last saw the deceased alive on Feb 1, 19 67, and that death occurred at 7:20 PM, from causes and on the date stated above.

22a. SIGNATURE: Edwin Davis Jr. M.D. — ATTENDING PHYS. [XX] MED DIRECTOR [ ] STAFF PHYS [ ]
22b. DATE SIGNED: 2/3/67
22c. PHYSICIAN'S NAME (Type): Edwin Davis, Jr. M.D.
22d. ADDRESS: 100 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2-4-67
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest
23d. LOCATION (City or Town) (County) (State): Annapolis A.A. MD.

24. FUNERAL DIRECTOR: Donald L. Lyle — ADDRESS: Annapolis, Md.
25a. RECD BY REGISTRAR DATE: FEB 8 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached and used as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01712

CERTIFICATE OF DEATH

01709

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): (Dead on Arrival) Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapplis
d. STREET ADDRESS: 188 Duke of Gloucester St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO XX

3 NAME OF DECEASED (Type or print): First: Arvilla — Middle: Sommers — Last: TAYLOR

4 DATE OF DEATH: Month: February — Day: 21 — Year: 1967

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐
8 DATE OF BIRTH: Nov. 4, 1890
9 AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME
10b KIND OF BUSINESS OR INDUSTRY: HOME
11 BIRTHPLACE (County & State or foreign country): Annapolis, Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Robert Sommers
14 MOTHER'S MAIDEN NAME: Arvilla Wells

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16 SOCIAL SECURITY NO: 218 36 3035 B
17 INFORMANT: D. S. Taylor — Address: #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary thrombosis ?
DUE TO (b): Arteriosclerotic C V D
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
INTERVAL BETWEEN ONSET AND DEATH: D.O.D. / yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Marked Obesity.

19 WAS AUTOPSY PERFORMED? YES ☐ NO XXX

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Jan, 1966 to 2-24, 1967 that (I) (We) last saw the deceased alive on 2-24 19 67 and that death occurred at 10:00 PM from causes and on the date stated above.

22a SIGNATURE: J McKinley
M.D. ATTENDING PHYS XX MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 2-23-67
22c PHYSICIAN'S NAME (Type): J. McKinley
22d ADDRESS: 121 Cathedral St., Annapplis, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 2-24-67
23c NAME OF CEMETERY OR CREMATORY: St. Hunes
23d LOCATION (City or Town) (County) (State): Annapolis MD.

24 FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.
25a REC'D BY REGISTRAR DATE: FEB 28 1967
25b REGISTRAR'S SIGNATURE: J Charles Judge

1 (M)

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01713

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01710

1. PLACE OF DEATH
a. COUNTY: A.A. CO.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ARNOLD, MARYLAND
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): O.O.A-Anne. Arundel. general.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD
b. COUNTY: A.A. CO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arnold
d. STREET ADDRESS: 313 Almada Pky.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Donald Middle: E. Last: Taylor

4. DATE OF DEATH: Month: 2 Day: 12 Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-19-59

9. AGE (In years last birthday): 7 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: Second Grade

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward E. Taylor

14. MOTHER'S MAIDEN NAME: Nancy Belt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): N.K.

16. SOCIAL SECURITY NO.:

17. INFORMANT: Edward E. Taylor Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH: Accidental
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fell thru ice in pond and drowned

20c. TIME OF INJURY Hour: a.m. / p.m. (p.m) Month, Day, Year: 2/12 19 67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Property Farm

20f. (City or town): [illegible] (County): AACO (State): MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

SIGNATURE: [signature] M.D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): E. Linhardt

Address (Street, city, town, or county):

DATE SIGNED: 2/12/67

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-15-67

22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem

22d. LOCATION (City, town, or country): Woodlawn Baltimore (State): Md

23. FUNERAL DIRECTOR: Robert S. Barranco ADDRESS: Severna Park, Md

24a. REC'D BY REGISTRAR DATE: FEB 15 1967

24b. REGISTRAR'S SIGNATURE: Charles Judge

ROBERT S BARRANCO

TO DEPUTY E[illegible]: The certificate should be executed within 24 hours after death. If any, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

3 1 B

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01714

CERTIFICATE OF DEATH

01711

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: Rt. 5, Box 76
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Guy — Middle Joseph — Last THOMAS
4. DATE OF DEATH: Month February — Day 10 — Year 19 67

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 16, 1903
9. AGE (In years last birthday): 63 ~~62~~ yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Civil Service
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John R. Thomas
14. MOTHER'S MAIDEN NAME: Carrie Johnson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Maggie Thomas Address: Annapolis Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Carcinoma Prostate — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
1717

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 8:35 P.M. from causes and on the date stated above.

22a. SIGNATURE: Theodore G. Osius M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: February 11, 1967
22c. PHYSICIAN'S NAME (Type): Theodore G. Osius M. D.
22d. ADDRESS: 77 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-14-67
23c. NAME OF CEMETERY OR CREMATORY: Brewer's
23d. LOCATION (City or Town) (County) (State): Edgewood Md.

24. FUNERAL DIRECTOR: William Reese — ADDRESS: Annapolis Md.
25a. REC'D BY REGISTRAR DATE FEB 14 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01715

CERTIFICATE OF DEATH

01712

1 PLACE OF DEATH
a. COUNTY: Anne-Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Annapolis Nursing and Convalescent Center

2 USUAL RESIDENCE (Where deceased lived, f institution Residence before admission)
a STATE: Maryland — b COUNTY: Baltimore
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d STREET ADDRESS: 622 Cator Ave
e S RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First JANE Middle C. Last VEDITZ
4 DATE OF DEATH: Month Feb. Day 19 Year 1967

5 SEX: F
6 COLOR OR RACE: Cauc.
7 MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: April 21, 1903
9 AGE (In years last birthday): 63 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary-Bookeeper
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State or foreign country): Baltimore, Md
12 CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Charles H Veditz
14 MOTHER'S MAIDEN NAME: Mary E. Asprin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: 212-22-6344
17. INFORMANT: Address: Mr. Robert Bouchelle 509 W. Pratt St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Carcinoma of the Lung — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept., 1966, to Feb., 1967, that (I) (we) last saw the deceased alive on 2/19/1967, and that death occurred at 11 P.M. from causes and on the date stated above

22a SIGNATURE: John A. Veditz M.D — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 2/19/67
22c. PHYSICIAN'S NAME (Type):
22d ADDRESS:

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 2/23/1967
23c NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery
23d LOCATION (City or Town) (County) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR: John A. Moran Inc. ADDRESS: 3000 E. Baltimore Street
25a REC'D BY REGISTRAR: FEB 24 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01716

CERTIFICATE OF DEATH

01713

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: 9 yrs. 2 mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Children's Center Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Ohio
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Granville
d. STREET ADDRESS: Our Lady of Mercy School
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alberta — Middle — Last: Virostek

4. DATE OF DEATH: Month: February — Day: 7 — Year: 1967

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 9/14/36
9 AGE (In years last birthday): 30 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Institutionalized
10b. KIND OF BUSINESS OR INDUSTRY: -------
11 BIRTHPLACE (County & State, or foreign country): Farrell, Pa.
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert Andrew Virostek
14. MOTHER'S MAIDEN NAME: Elizabeth Bernadetta (Tobasco)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO:
17 INFORMANT Address: Children's Center Hospital, Laurel, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Aspiration of food — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b): Mental retardation
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from Nov. 1, 1957, to Feb. 7, 1967, that (I) (we) last saw the deceased alive on Feb. 7, 1967, and that death occurred at 9:05 AM, from causes and on the date stated above.

22a SIGNATURE: George T. Economos, M.D. — ATTENDING PHYS ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b DATE SIGNED: 2/7/67
22c. PHYSICIAN'S NAME (Type): GEORGE T. ECONOMOS, M. D.
22d. ADDRESS: Children's Center Hospital, Laurel, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 2-9-1967
23c NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery
23d LOCATION (City or Town) (County) (State): Silver Spring, Md.

24 FUNERAL DIRECTOR: Joe Gawler's Sons, Inc
ADDRESS: 5130 Wisconsin Ave. N.W. Wash. D.C.
25a REC'D BY REGISTRAR DATE: FEB 14 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01717 — 01714

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 7 mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Baltimore Infirmary, Inc. Dept. Ld, Dr.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 730 Magate Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: E — Last: Walker

4. DATE OF DEATH: Month: 2 — Day: 21 — Year: 1967

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 3-23-891 — 9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown (Ret) — 10b. KIND OF BUSINESS OR INDUSTRY: Self-Emp — 11. BIRTHPLACE (County & State, or foreign country): Tennessee — 12. CITIZEN OF WHAT COUNTRY? U.S. Amer.

13. FATHER'S NAME: Unknown — 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Unknown — 16. SOCIAL SECURITY NO.: 209-09-4946 — 17. INFORMANT: Address: Mrs Drusilla Newport (Daughter)

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 Day

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Pulmonary Congestion — 1 Day
DUE TO (c): Cerebral Arteriosclerosis — Several years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/29/66 to 2/21/67 that (I) (we) last saw the deceased alive on 2/18/67, and that death occurred at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Richard H. Hunt M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: Feb 21 1967

22c. PHYSICIAN'S NAME (Type): Richard H. Hunt — 22d ADDRESS: 100 Century Lane, Glen Burnie, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b DATE THEREOF: 2/25/67 — 23c. NAME OF CEMETERY OR CREMATORY: Lorraine Park Cemetery — 23d. LOCATION (City, town or county) (State): Balto Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Robert Hughes — ADDRESS: Singleton Funeral Home / Glen Burnie, md — 25a. REC'D BY REGISTRAR DATE: FEB 24 1967 — 25b. REGISTRAR'S SIGNATURE: Charles Suggs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01718

CERTIFICATE OF DEATH

01715

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a COUNTY: ANNE ARUNDEL — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ANNE ARUNDEL GENERAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: MARYLAND — b COUNTY: ANNE ARUNDEL
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIVA
d. STREET ADDRESS: WHITE HOUSE ROAD
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT — Middle F. — Last WALSTON, Sr.

4. DATE OF DEATH: Month FEB — Day 13 — Year 1967

5. SEX: M

6. COLOR OR RACE: CAU

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 27 JAN 1909

9. AGE (In years last birthday): 58 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): USNAVALACAD

10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOVT

11. BIRTHPLACE (County & State, or foreign country): FAIRMOUNT, MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Hays Walston

14. MOTHER'S MAIDEN NAME: Addie May Hurley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Laura R. Walston — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): VENTRICULAR FIBRILLATION — INTERVAL BETWEEN ONSET AND DEATH: ½ HOUR
DUE TO
(b): MYOCARDIAL INFARCTION — 2 HOURS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — UNKNOWN

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): HYPERTENSION, UNCONTROLLED DIABETES, OBESITY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from FEB 13, 1967 to FEB 13, 1967, that (I) (we) last saw the deceased alive on FEB 13 1967, and that death occurred at 10 P M, from causes and on the date stated above.

22a. SIGNATURE: Charles W. Kinzer M.D. — ATTENDING PHYS ☒ — MED DIRECTOR ☐ — STAFF PHYS ☐

22b. DATE SIGNED: 13 FEB 1967

22c. PHYSICIAN'S NAME (Type): CHARLES W. KINZER, M.D.

22d. ADDRESS: SOUTH RIVER MEDICAL CENTER, EDGEWATER, MARYLAND 21037

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-16-1967

23c. NAME OF CEMETERY OR CREMATORY: Edwards Chapel

23d. LOCATION (City or Town) (County) (State): Annapolis Md.

24. FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.

25a. RECD BY REGISTRAR DATE: FEB 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01719 01716

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: NINE MONTHS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. NAVAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 8 SOUTH HAVEN ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BRENDA — Middle: SUE — Last: WALTER

4. DATE OF DEATH: Month: FEBRUARY — Day: 4 — Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3 MARCH 1965

9. AGE (In years last birthday): 1 yrs. — IF UNDER 1 YEAR: Months — IF UNDER 24 HRS.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NA

10b. KIND OF BUSINESS OR INDUSTRY: NA

11. BIRTHPLACE (County & State, or foreign country): CHINA LAKE, CALIFORNIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BARRY LEE WALTER

14. MOTHER'S MAIDEN NAME: PATRICIA IRENE FERGUSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: NA

17. INFORMANT — Address: BARRY LEE WALTER, 8 SOUTH HAVEN ROAD, ANNA, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONIA
DUE TO (b): CONGENITAL HEART DISEASE (VSD)
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 36 HOURS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4 FEB, 19 67, to 4 FEB, 19 67, that (I) (we) last saw the deceased alive on 4 FEB 19 67, and that death occurred at 1:50 PM, from the causes and on the date stated above.

22a. SIGNATURE: Charles L. Gaudry — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4 FEBRUARY 1967

22c. PHYSICIAN'S NAME (Type): CHARLES L. GAUDRY

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Feb. 7, 1967

23c. NAME OF CEMETERY OR CREMATORY: U.S. Naval Cemetery

23d. LOCATION (City, town or county) (State): Annapolis MD

24. FUNERAL DIRECTOR: BEALE FUNERAL HOME — ADDRESS: [illegible] Annapolis, Md

25a. REC'D BY REGISTRAR — DATE: FEB 9 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01720

CERTIFICATE OF DEATH

Reg. Dist. No. 01717

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Knollwood Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riviera Beach
d. STREET ADDRESS: 217 Meadow Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edith; Middle: A.; Last: WATTS

4. DATE OF DEATH: Month: Feb; Day: 22; Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 24 Oct. 1877

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nursing Aid

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Tunstall

14. MOTHER'S MAIDEN NAME: Elizabeth Betts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 013-24-6050A

17. INFORMANT: Albert E. Jones (Son) Same as #2
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Cardio Vascular Disease — 10 YRS

DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from APRIL 19 62 to 2/27 19 67 that I last saw the deceased alive on 2/21 19 67, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Brady Smith M.D.
ADDRESS (Street, city or town, state): 8471 Ft. Smallwood Road
DATE SIGNED: 2/27/67

PHYSICIAN'S NAME (Type): J. BRADY SMITH
Pasadena, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3 MARCH 67
22c. NAME OF CEMETERY OR CREMATORY: Hope Cemetery
22d. LOCATION (City, town, or county) (State): Worcester Mass

23. FUNERAL DIRECTOR'S SIGNATURE: Robert P. Lane
ADDRESS: Singleton Funeral Home / Glen Burnie, md.

24a. REC'D BY REGISTRAR DATE: MAR 1 1967
24b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01721

CERTIFICATE OF DEATH

01718

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CROWNSVILLE
c. LENGTH OF STAY IN 1b: 1/28/67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CROWNSVILLE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD
b. COUNTY: Balt. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE
d. STREET ADDRESS: 36 S. FREMONT AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HARVEY — Middle: / — Last: WEEKS

4. DATE OF DEATH: Month: 2 — Day: 11 — Year: 1967

5. SEX: M

6. COLOR OR RACE: N

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/28/96

9. AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Z Retired

10b. KIND OF BUSINESS OR INDUSTRY: Z

11. BIRTHPLACE (County & State, or foreign country): MANNASSAS, Va

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRANKLIN WEEKS

14. MOTHER'S MAIDEN NAME: CAROLINE CRAMBLETT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: ?

17. INFORMANT — Address: HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BRONCHO PNEUMONIA
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I (this hospital) attended the deceased from 1/28/67, 19__, to 2/11/67, 19__, that I (we) last saw the deceased alive on 2/11/67 19__, and that death occurred at 5:40 AM, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/12/67

22c. PHYSICIAN'S NAME (Type): L. BENEDICT M.D.

22d. ADDRESS: Crownsville State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-14-67

23c. NAME OF CEMETERY OR CREMATORY: Good Shepherd

23d. LOCATION (City or Town) (County) (State): Md

24. FUNERAL DIRECTOR: Thelma A Hoffman — ADDRESS: 3218 Hudson St

25a. REC'D BY REGISTRAR: DATE FEB 16 1967

25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01722

CERTIFICATE OF DEATH

01719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galesville
d. STREET ADDRESS: Box-25
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Chesterfield — Middle: — Last: WHITE

4. DATE OF DEATH: Month: February — Day: 2 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 9, 1892

9. AGE (In years last birthday): 74 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Benjamin White

14. MOTHER'S MAIDEN NAME: Elizabeth Booze

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-07-8403

17. INFORMANT: Christina White — Address: Galesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the esophagus — INTERVAL BETWEEN ONSET AND DEATH: 6 months or more
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) attended the deceased from Dec 1, 19 66, to Feb. 2, 1967, that (I) last saw the deceased alive on Feb. 2, 19 67, and that death occurred at 9:00 PM M, from causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith, M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 2/3/67

22c. PHYSICIAN'S NAME (Type): Willard F. Smith, M.D.

22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-7-1967

23c. NAME OF CEMETERY OR CREMATORY: Ebenezer

23d. LOCATION (City or Town) (County) (State): Galesville, Md.

24. FUNERAL DIRECTOR: William Kasel — ADDRESS: Md.

25a. REC'D BY REGISTRAR DATE: FEB 6 1967

25b. REGISTRAR'S SIGNATURE: Charles Yeager

Item 2 Phone F.Dir. 3-3-67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G386 3/6/67 mh

01723

CERTIFICATE OF DEATH

01720

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
   c. LENGTH OF STAY IN 1b: 1 yr. 4 month
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: —
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 30-4
   d. STREET ADDRESS: 1702 Sexton St. ~~-189 Meadow Road~~
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): #30608 Laura (First) Dean (Middle) Wise (Last)

4. **DATE OF DEATH**: Month 2 Day 27 Year 1967

5. SEX: Female F

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/3/1884

9. AGE (In years last birthday): 82 82 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Calub Dean

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. **INFORMANT** Address: Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Bronchopneumonia — 491X — INTERVAL BETWEEN ONSET AND DEATH
   DUE TO (b): —
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   DUE TO (c): —

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CChronic Brain Syndrome sec. to Cerebral Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ---

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 ---

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---

20f. (City or town) (County) (State) ---

21. **I certify** that (I) (this hospital) attended the deceased from 10/29/, 1965, to 2/27/, 1967, that (I) (we) last saw the deceased alive on 2/27/ 1967, and that death occurred at 6:00 A. M, from causes and on the date stated above.

22a. SIGNATURE: [signature]

M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 2/27/67

22c. PHYSICIAN'S NAME (Type): L. Benedict, M.D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/2/67

23c. NAME OF CEMETERY OR CREMATORY: Joy Chapel Cemetery

23d. LOCATION (City or Town) (County) (State): St.Mary's Co.-Maryland

24. FUNERAL DIRECTOR ADDRESS: Robert C. Altenburg-6009 Harford Rd. Funeral Home, Inc.

25a. REC'D BY REGISTRAR DATE: MAR 3 1967

25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01724 — 01721

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie-rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn Park-rural
d. STREET ADDRESS: 313 17th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: James — Middle: W. — Last: Wood
4. DATE OF DEATH: Month: 2/18/67 — Day — Year: 19

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/16/52
9. AGE (In years last birthday): 14 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jack M Wood
14. MOTHER'S MAIDEN NAME: Vivian Pupert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Family — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carbon monoxide poisoning associated with smoke
DUE TO: and soot inhalation
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Conflagration
20c. TIME OF INJURY Month, Day, Year, Hour o.m.: 2:00 xx 2 18 19 67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): shack
20f. (City or town) (County) (State): Brooklyn Pk. A.A. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):
22. DATE SIGNED: 2/19/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/20/67
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven
23d. LOCATION (City or Town) (County) (State): Glen Burnie AA CO Md

24. FUNERAL DIRECTOR — ADDRESS: McCully F H 237 Patapsco Ave 21225
25a. REC'D BY REGISTRAR DATE: FEB 20 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67